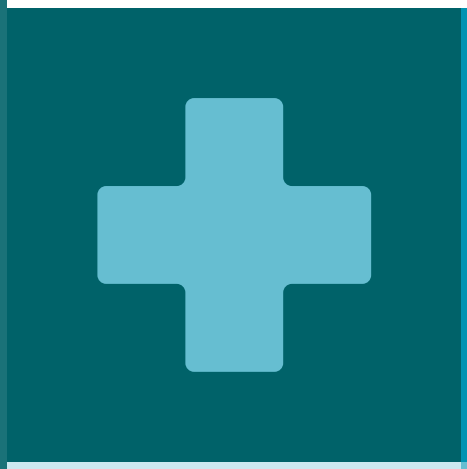
Australian Government

Department of Health, Disability and Ageing

Corporate Plan



2026–27

Artist: Brad Hore

Acknowledgement of Country

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

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Secretary's Foreword

I'm pleased to present the Department of Health, Disability and Ageing's 2026–27 Corporate Plan. This plan sets out how we will deliver the Australian Government's priorities over the next 4 years and how we will measure our performance as stewards of Australia's health, disability and aged care systems.

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).

The plan reflects the 2026–27 Budget and the government's reform agenda across primary care, hospitals, aged care, medicines and the National Disability Insurance Scheme (NDIS). It responds to rising demand, population ageing, increasing chronic and complex conditions, workforce pressures and changing community expectations.

Our task is not only to deliver reform, but to make choices that balance access, quality and equity with long-term sustainability, workforce capacity and system efficiency.

A stronger primary care system is central to this work. We are improving access to affordable care through enhanced bulk billing incentives, supporting all Australians, including priority populations and areas experiencing workforce shortages.

We are supporting multidisciplinary care models, better digital integration and stronger links across care settings. These actions will improve continuity of care and reduce avoidable hospital demand.

Securing the long-term sustainability of the NDIS is a priority. We will keep the scheme centred on participants while improving consistency, planning, early intervention, foundational supports and market stewardship. This includes clarifying the roles of the NDIS and mainstream services.

In aged care, we continue to progress major reform to increase supply and improve quality, safety and accountability. This includes implementing a stronger regulatory framework, improving transparency, and supporting workforce capability. We are also reshaping funding settings, which better align incentives with quality outcomes and consumer choice.

Finally, the Pharmaceutical Benefits Scheme continues to be a vital foundation in the Australian health system. With our colleagues in the Therapeutic Goods Administration, we will ensure that Australians can access medicines that are safe and affordable.

Our long-term strategic priorities serve as guiding principles to shape policy and deliver across the department. These priorities are pivoting to prevention, and early intervention, improving equity, leveraging digital and health technology and ensuring systems integration.

Many of the challenges we face do not sit within one system, portfolio or level of government. We recognise that better outcomes depend on stronger integration across health, disability, aged care and other social and economic systems. We will use data, evaluation and effective partnerships to support better outcomes across these systems.

We remain committed to genuine partnership with Aboriginal and Torres Strait Islander people. Our actions will include support for community-controlled organisations, culturally safe services and respect for self-determination.

Working with governments, service providers and the community, we will continue to build more connected, sustainable and person-centred systems for Australians.

Blair Comley PSM
Secretary

Role of the Corporate Plan

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

Together with the 2026–27 Health, Disability and Ageing Portfolio Budget Statements (PB Statements), 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 PB Statements. Since the 2026–27 PB Statements, we have made some changes to our performance measures. These changes are documented throughout the performance information sections. We will report against them in our 2026–27 annual performance statements.

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.

Outcome 1 – Health Policy, Access and Support

1.1 Health Research, Coordination and Access

1.2 Mental Health and Suicide Prevention

1.3 First Nations Health

1.4 Health Workforce

1.5 Preventive Health and Chronic Disease Support

1.6 Primary Health Care Quality and Coordination

1.7 Primary Care Practice Incentives and Medical Indemnity

1.8 Health Protection, Emergency Response and Regulation

1.9 Immunisation

Outcome 2 – Individual Health Benefits

2.1 Medical Benefits

2.2 Hearing Services

2.3 Pharmaceutical Benefits

2.4 Private Health Insurance

2.5 Dental Services

2.6 Health Benefit Compliance

2.7 Assistance through Aids and Appliances

Outcome 3 – Ageing and Aged Care

3.1 Access and Information

3.2 Aged Care Services

3.3 Aged Care Quality

Outcome 4 – Disability and Carers

4.1 Disability and Carers

4.2 National Disability Insurance Scheme

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

Health Products Regulation

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

Systems Strategy

- Portfolio Strategy
- Evidence and Research
- Office of the Chief Health Economist

Ageing and Aged Care

- Reform Implementation
- Access and Home Support
- Quality and Assurance
- Dementia, Diversity and Residential Care
- Market and Stewardship
- Service Delivery

Health Resourcing

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

Primary Care, Community and First Nations

- Population Health
- Chronic Conditions and Screening
- Primary Care
- Mental Health and Suicide Prevention
- First Nations Health
- National Mental Health Commission

Disability and Carers

- Carers, Autism, Markets and Safeguards
- Disability Strategy, Supports and Inclusion
- NDIS Strategy and Policy
- Thriving Kids Taskforce
- NDIS Sustainability Taskforce

Corporate Operations

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

Our partners

Our partnerships are central to effective stewardship of Australia's health, disability and aged care systems.

We collaborate with government departments, our portfolio agencies and state and territory governments to integrate policy and investments to enable long term system improvements.

We work with a wide range of partners across the health, disability and aged care systems to design, deliver and improve services for all Australians. They include:

- researchers
- representative organisations
- aged care providers and workers
- primary care professionals and their peak bodies
- the private health sector.

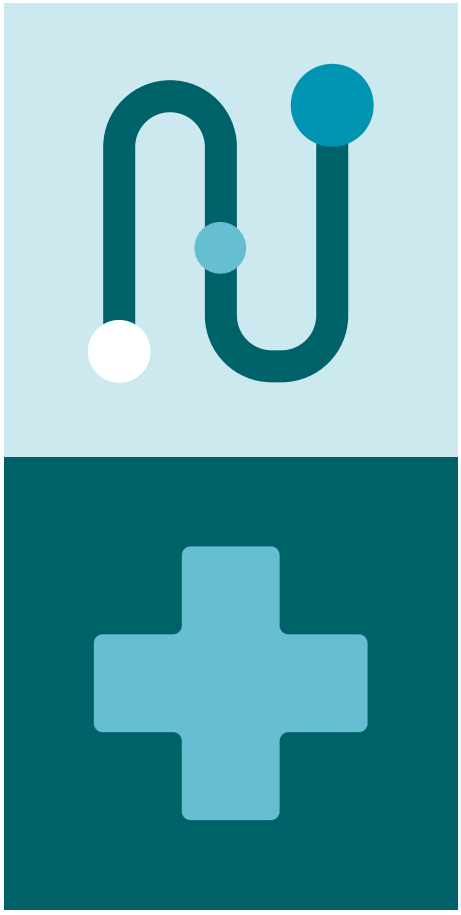
These partnerships help us progress evidence-based reform, improve quality and safety, and support more connected and person-centred services.

Improving health and wellbeing outcomes for the Australian public is our enduring focus. We are committed to engaging with, and learning from, the people who use health, disability and aged care services.

Aboriginal and Torres Strait Islander organisations and communities are essential partners in delivering culturally safe services and helping us in Closing the Gap. We are committed to genuine partnership and shared decision-making.

Internationally, we engage with key organisations to support Australia's health priorities and strengthen regional and global health security, including the:

- World Health Organization
- G20
- Organisation for Economic Co-operation and Development
- United Nations Committee on the Rights of Persons with Disabilities.



Our operating context

Australia's health, disability and aged care systems operate in a complex, interconnected environment. They span all levels of government, as well as public, private and not-for-profit providers. Each system has distinct legislative, funding and service-delivery arrangements.

Geopolitical uncertainty, supply chain disruption, emerging technologies and global health risks continue to test the resilience and sustainability of these systems.

Most Australians interact with one or all of these systems in their daily lives, particularly older people, people with disability, and those with chronic and complex conditions.

Stronger information sharing and better system design are critical to reducing fragmentation and improving outcomes. Initiatives like MyMedicare and enhancements to My Health Record help patients and health professionals access more reliable and timely health data and reduce duplication. Reforms to aged care and the NDIS include a strong focus on improving the underpinning design of these systems to make them both more effective and more efficient.

Common structural pressures are reshaping demand, service delivery and sustainability across these systems. Our ageing population, increasing rates of chronic and complex health conditions, and changing consumer expectations drive increased demand for services. Disability and aged care services are also impacted by growing workforce costs and shortages.

There are real opportunities to improve outcomes by improving integration. Better aligned care pathways, coordinated assessments, shared workforce approaches and stronger data integration can also make services easier to navigate and support long term sustainability.

Access to care and support is also shaped by social and geographic factors. People in rural and remote areas, and those experiencing disadvantage, often face greater barriers to accessing timely and appropriate services. Place and technology-based responses are critical to improving equity and outcomes.

Climate-related events, changing disease patterns and emerging infectious disease risks are adding further complexity. These pressures reinforce the need for preparedness, resilience and strong national capability in prevention, monitoring and response. We have activated the National Incident Centre to respond to recent overseas outbreaks of hantavirus and Ebola, as well as local cases of diphtheria. This has resulted in a coordinated response across governments, including close collaboration with the recently established Australian Centre for Disease Control.

Our stewardship role has become increasingly important. This requires a stronger focus on system design, integration, evidence and outcomes, supported by contemporary capability, effective partnerships, and clear performance and accountability.

Our regulatory approach

The department regulates and administers a broad range of health, disability and ageing related grants and procurement activities. We ensure alignment between legislative and policy requirements and support the delivery of government priorities. This regulatory role extends across the following systems:

- Ageing and aged care services
- Controlled drugs
- Disability supports and services
- Food standards
- Gene technology
- Health and aged care related grants
- Health professional practice, through joint ministerial responsibilities for the National Registrations and Accreditation Scheme
- Health promotion
- Health research and data
- Health security and international health
- Human cloning and embryo research
- Industrial chemicals
- Medical, pharmaceutical, dental and hearing benefits
- 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.

We also work with our regulatory partners across the portfolio. These include the Aged Care Quality and Safety Commission, NDIS Quality and Safeguards Commission, National Health and Medical Research Council, and the Professional Services Review Scheme.

We lead and shape Australia's health, disability, and aged care systems with best practice regulation, evidence-based policy and well-targeted programs. Our approach places consumers at the centre of regulatory decision-making, by ensuring that the safety, wellbeing, and needs of individuals and communities are prioritised. Meanwhile, we also support continued productivity, innovation and sustainable growth in these systems.

Guided by the government's Regulatory Policy, Practice & Performance Framework, we will continue to modernise our approach. This means embracing digital innovation, streamlining processes, and reducing unnecessary regulatory burden. Our regulators will ensure regulation remains fit-for-purpose, proportionate and responsive to emerging challenges and opportunities, thereby supporting public value and economic resilience. Consistent with principles of regulatory stewardship, regulation should protect community health and safety while remaining efficient to administer and comply with legislative requirements.

Statements of Expectation (SOE) set out the ministers' expectations of how the department's regulators will carry out their regulatory functions. In turn, Statements of Intent (SOI) set out how the various regulators will deliver on the minister's expectations. The various SOEs and SOIs for the department's regulators can be found on the Australian Government Regulator Stocktake.[1]

1 Department of Finance, **Australian Government regulator stocktake**, Department of Finance, n.d., accessed June 2026

Corporate governance and risk oversight

Corporate governance plays an integral role in ensuring 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 the 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 2025–26, 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

Provides oversight to the department's digital, data and information communication and technology (ICT) functions. The Committee provides executive custodianship across both sustaining functions and transformation programs to drive strategic digital enablement across systems.

Two other important committees help guide our work:

- The Strategic Policy Forum looks across the entire portfolio to support the development and improvement of policies.
- The Closing the Gap Steering 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.

We have 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, while 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 and an internal audit program to provide independent advice on the appropriateness of our 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 - Re cruitment 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 sets out 4 aims that the Corporate Operations Group seeks to achieve through the services we deliver and the functions we perform:

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

Each aim is supported by defined indicators and targets, providing a structured foundation to progressively improve corporate services and functions. The Corporate Strategy 2024–2027 is underpinned by the Corporate Transformation Plan 2024–2025 to 2026–2027, which sets out the major projects that will deliver tangible benefits for our customers. These projects will drive transformational change and ensure the department is equipped to operate in a rapidly evolving environment by:

- building workforce and leadership capability
- sharpening enterprise performance
- strengthening our integrity culture
- leveraging digital opportunities.

The portfolio of major projects is reviewed at least annually to ensure it reflects emerging priorities and opportunities for the department.

Monitoring performance against the strategy's aims and the delivery of planned project benefits, alongside ongoing engagement with our executive, ensures our services, functions and planning at divisional, branch and section levels remain aligned with departmental priorities.

Workforce capability

The department continues to build capability in key areas identified through the 2023 Department of Health and Aged Care Capability Review (the Capability Review). We are also implementing Australian Public Service (APS) Reform agenda initiatives.[2]

The Capability Review outlined 3 complementary themes that underpin our response:

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

In 2026-27, we will continue to provide development opportunities for our staff. These will be delivered both internally and through offerings delivered in partnership with the APS Academy. We are advancing Executive Level leadership and management development through our ELevate and Activate programs, complemented by the introduction of an Executive Level 2 Forum. This year places a stronger emphasis on supporting our leaders to guide their teams through change and strengthening capability and confidence to adapt with shifting priorities. We will review stakeholder engagement strategies and how we gather feedback from our stakeholders, and continue to grow our engagement capability.

2 Australian Public Service Commission (APSC), **APS Reform**, APSC, 2025, accessed June 2026

Our Workforce Strategy

We have a workforce of around 7,000 APS employees around Australia. The largest proportion of roles across the department are within the job families of Policy; Portfolio, Program and Project Management; Compliance and Regulation; and Business and Organisation Management.

Our Workforce Strategy has 4 strategic objectives:

1. Compete for talent
2. Grow our own
3. Support and build agility
4. Leadership and culture.

Our vision is to build a capable, agile, and future-ready workforce.

Our workforce planning approach, supported by annual environmental scans, identifies the capabilities needed to meet our strategic objectives.

These activities also guide the priority actions set out in the annual implementation plan.

Our focus areas for 2026-27 are:

1. Building capability to enable successful adoption of artificial intelligence (AI) and automation
2. Embedding agility and resilience in our workforce design and workforce mobility
3. Strengthening leadership and culture to drive inclusion and performance.

Under the Workforce Strategy, the Learning and Development Roadmap outlines the key learning and development actions for the year ahead. These align to the capability needs identified in the Workforce Strategy and Capability Review Response.

In 2026–27, we will support managers through the introduction of flexible new management offerings. This delivers on our commitment to strategic AI capability uplift, and maintains a strong focus on learning evaluation, reporting and analysis. It also ensures our investment in staff development is targeted, effective and evidence based.

We're committed to ensuring APS employment is the default and we maximise the benefit of external arrangements through implementing the principles of the APS Strategic Commissioning Framework.[3]

This financial year, we will continue to reduce outsourcing of core work in line with the APS Strategic Commissioning Framework. We anticipate a reduction of $320,957 in outsourcing expenditure.

Our focus will be reducing outsourcing in the job families of:

- Accounting and Finance
- Business and Organisational Management
- Communications and Engagement
- Compliance and Regulation
- Legal and Parliamentary
- Policy
- Portfolio, Program and Project Management
- Service Delivery.

3 APSC, **APS Strategic Commissioning Framework**, APSC, 2023, accessed June 2026

Workplace culture

Our department gives our workforce the opportunity to shape Australia's health and wellbeing. This is a key part of our Employee Value Proposition.

We have a strong sense of self and purpose, clear values, and a supportive professional culture, with a shared commitment to making a difference. A review in 2025–26 into the department's leadership and culture highlighted strong ethical foundations, inclusive practices, and growing clarity of purpose.

It identified a need for more consistent leadership expectations and a refreshed behavioural framework aligned with APS Values and hybrid working needs.

Perception of our leaders remains strong. We support their wellbeing and empower them to lead hybrid and geographically dispersed teams effectively.

A positive workplace culture is underpinned by strong, respectful and inclusive leadership. We invest in the development of our leaders to foster environments where people feel supported, valued and empowered to do their best work. We've invested in initiatives such as the EL2 Leadership Development program and 360-degree feedback reviews for the Senior Executive Service (SES). These promote self-awareness, constructive feedback and continuous improvement, while reinforcing shared leadership expectations and accountability. We also encourage SES leaders to undertake ongoing professional development to strengthen cultural capability and inclusive leadership practice, recognising that culturally informed leadership supports trust, collaboration and better outcomes. Together, these initiatives help embed a culture of learning, respect and integrity across the department.

We prioritise a strong integrity culture and take care to operate securely to deliver strong, high quality and defensible outcomes in line with the expectations of government. We ensure our people are eligible and suitable for their role and the access they are entrusted with. The New Ways of Working (NWOW) program is reaching the end of its multi-year uplift to our work environments, delivering modern, flexible spaces that enable our staff to do their best work. We are now focussed on embedding changes and evolving our operations to best support our people to deliver together. Our workforce is now predominantly hybrid and increasingly spread across locations. This is combined with a high uptake of flexible work hours and work patterns. In the coming year, we will work to build effective hybrid practices as a deliberate, strategic capability for the department. When done well, hybrid work strengthens our ability to deliver on government priorities and supports staff development and wellbeing.

Diversity and inclusion

Diversity and inclusion in action supports a thriving workforce. An inclusive and culturally capable department enables better judgement, stronger collaboration, and services that are safer, more accessible, and more responsive to the communities we serve.

To achieve this, we are committed to being inclusive, culturally aware and responsive in our policies, practices and our ways of working. We actively pursue initiatives that enhance diversity and inclusion across multiple dimensions, including gender, age, disability, LGBTIQA+, neurodivergence, Aboriginal and/or Torres Strait Islander people and cultural diversity.

This work is underpinned by our Inclusion Framework 2025–30 and our Stretch Reconciliation Action Plan 2025–2028 (RAP), which together embed inclusion and cultural safety as core organisational capabilities.

The Inclusion Framework 2025–30 applies a holistic, data driven approach to ensure workforce inclusion, focusing on leadership capability, inclusive systems, and employee experience. Using workforce data and staff insights, the Inclusion Framework guides targeted action to improve equity, belonging, and representation, while strengthening decision-making and organisational effectiveness.

The RAP aims to embed reconciliation into how we lead, partner, and deliver services. Complementing the work of our Closing the Gap Steering Committee, the RAP drives action aligned with the Closing the Gap Priority Reforms and strengthens cultural safety across the department.

Key themes of the RAP focus on:

- recruitment and retention
- cultural capability in our leaders
- using procurement, grants, partnerships and engagement to increase opportunities for Aboriginal and Torres Strait Islander people
- cultural safety.

Building on diversity and inclusion, the department is also supported by 6 staff diversity networks that provide connection and peer support, while contributing lived experience and insight to strengthen inclusive decision-making and organisational practice. These are our:

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

By focusing our diversity and inclusion agenda on outcomes, we will strengthen organisational performance, reduce risk, and build trust with the communities we work with, ensuring inclusion is not an initiative alongside our work, but an intrinsic part of how we operate.

Infrastructure

The department operates in an increasingly complex security environment. Through our Agency Security Plan, we maintain and strengthen security infrastructure and controls across physical, personnel, information and technology domains. We manage infrastructure security in accordance with the Protective Security Policy Framework, using risk-based controls and assurance activities. This protects people, systems and information, supports continuity of operations, and ensures the capability to deliver trusted government services.

We have progressively implemented activity-based office fit-outs through the NWOW program, enabling flexible work environments that support staff to work in a range of settings, including remotely. The NWOW program has continued to achieve its intended benefits of increased staff satisfaction with workplace, technology and culture; increased organisational alignment and responsiveness; and decreased departmental costs. The final sites in scope of the NWOW program to undergo refurbishment works fit-out will be completed in 2026–27.

Climate action in government operations

We continue to support the government's efforts to improve energy efficiency and reduce greenhouse gas emissions in line with the APS Net Zero 2030 policy. The Net Zero and Climate Risk Committee, chaired by the Chief Sustainability Officer, oversees our implementation of initiatives to promote sustainable practices and strengthen climate awareness. This includes monitoring progress against the Emissions Reduction Plan and supporting annual reporting under the Commonwealth Climate Disclosure requirements.

We have developed an organisational-level climate risk and opportunity profile using the Climate Risk and Opportunity Management Program Digital Tool. We're in the process of identifying practical priority actions for the next phase of implementation. In 2026–27, we will focus on targeted intervention in sustainable procurement and climate risk integration into business and risk planning.

Information communications and technology capability

Our Digital Services teams work to deliver a person-centred, digitally-integrated ecosystem that enables better health, care and support for all Australians, now and into the future. Our strategic goals ensure:

- people are digitally empowered to improve their health and wellbeing
- people have accessible, inclusive and personalised digital health, care and support experiences
- our workforce is digitally empowered to provide safe, high-quality care outcomes
- we have a modern, secure, data-driven ecosystem that fosters innovation.

These efforts support us to deliver on government priorities by safeguarding the systems and data that support our programs, projects, and services. They also help us to strengthen governance and security, including in response to the increasing scale and use of AI.

Digital strategy and investment priorities

The department recognises health, care and support services can be transformed through better planned and delivered digital services. We are increasingly seeking to manage digital initiatives as a connected portfolio to:

- reduce fragmentation
- improve reuse and interoperability
- drive long-term sustainability of health, disability and aged care programs.

Robust leadership, with governance and assurance through the Digital Committee and subcommittees, ensures strong returns on our digital investments. Our Digital Investment Plan underpins a rigorous prioritisation process, informed by our ongoing work to understand and uplift both our own digital maturity and the maturity of the sectors we steward.

We collaborate across the portfolio and partner closely with stakeholders to align our digital, data and ICT strategies and respond to emerging challenges.

We define and maintain our enterprise architecture principles and reference architectures to guide the design, integration and evolution of the department's technology landscape. We identify opportunities for reuse and interoperability across systems and architectures, supported by a standardised approach to ICT delivery to ensure solutions are fit-for-purpose and scalable.

User-centred design practices, including user research, service design and interaction design, are applied across health, disability and aged care initiatives. Together, these efforts support the delivery of government priorities, help maximise the value of digital investments in a challenging global economic environment, and strengthen partnerships across government and the sectors we work with and steward.

The 2026–27 iteration of the Digital Investment Plan articulates a 10-year plan to use digital to:

- streamline and modernise the delivery of health, and care and support services
- support the safe use of innovative digital technologies, including AI, to boost productivity and reduce administrative burden
- enable greater workforce mobility across health, disability and aged care
- help people access and navigate services that best meet their needs
- improve the flow of information across health, aged care and the broader care and support sectors.

By focussing on evidence, co-design and capability uplift across the portfolio, we help ensure digital investments are informed by real needs and deliver meaningful outcomes for people in Australia.

Cyber security

We foster collaborative cybersecurity initiatives across agencies and implement shared capability uplift programs with our partners to boost ICT proficiency and skills.

The Department of Health and Aged Care Security Strategy 2023–26 is nearing conclusion. It has established a strong foundation for strengthened cyber security protections.

Building on this progress, a new strategy will be developed to set clear direction and measurable goals to further enhance the department's security and cyber resilience.

ICT sourcing

We align with contemporary whole-of-government procurement policies through the ICT Sourcing Strategy. We are transitioning to a flexible, scalable, sustainable and resilient multi-vendor ICT model, replacing the legacy single-vendor arrangement. This model improves service quality, digital resilience and stability. It also delivers better value for money while ensuring continuity of critical services and improved employee digital experience. We will complete transition activities in 2026–27, providing lower cost and better quality digital services for the department and our portfolio agencies.

Artificial intelligence

The department is committed to safe, ethical and responsible use of AI.

We align with the whole-of-government approach for the safe and responsible adoption and use of AI. Our Artificial Intelligence Accountable Official leads the implementation of the AI Plan for the Australian Public Service 2025 for our department, as set out in our AI transparency statement. We apply robust governance arrangements around the use of AI while continuing to uplift staff capability in AI literacy and responsible use. This includes overseeing the review of our AI Management System and its alignment with the Australian Government AI Technical Standard, and the Digital Transformation Agency's Policy for the Responsible Use of AI in Government.

This work strengthens governance, policy and assurance arrangements across the full AI life cycle from identifying use cases to deployment and ongoing monitoring. Our goal is to ensure AI is embedded thoughtfully within our technology ecosystem, complementing existing capabilities and delivering genuine value while upholding the trust the Australian community places in us.

Digital maturity and capability

The Digital Maturity Assessment we undertook in 2025-26 provides an evidence-based view of current digital capability and readiness for future business needs. It will inform how the department will grow and maintain capability across governance, workforce, delivery and enabling technologies, ensuring alignment with broader digital trends, including data-driven services and responsible use of AI. In 2026–27, insights from the assessment will be used to guide targeted improvements through cooperation, co-investment and shared services across government. Measuring our maturity enables our performance to be tracked over time, helping us understand how strengthening ICT capability is contributing to better outcomes, value for money and effective stewardship across health, disability and aged care.

Digital Services will support the department's future business requirements by:

- adopting scalable cloud-based solutions to enable flexibility and growth
- prioritising cybersecurity to protect sensitive data and maintain business continuity
- integrating emerging technologies such as AI and automation to improve operational efficiency
- enhancing digital infrastructure to support remote and hybrid working models
- investing in workforce uplift to ensure staff can leverage new tools effectively
- uplifting system security and management
- simplifying mail flow moving to modern security and compliance solutions
- continuing to uplift collaboration capabilities for our workforce.

Economic capability

We recognise the value of uplifting economic capability and building an economic evidence base to inform policy. The macro and microeconomic environments in which we, and the sectors we steward, further highlight the importance of thorough economic analysis. Global shocks, technological advancement, including AI and population ageing, offer both opportunities and challenges. Health, disability and aged care represent a large and growing share of government spending. The care economy is also a large part of the broader economy, employing 16.3% of working Australians.[4] These sectors contribute to economic growth by supporting Australia's increasing labour market participation rate.

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 economic principles and practices to policy design
- help build economic capability in the department.

The Office of the Chief Health Economist (OCHE) 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 approaches, early peer review and partnerships.

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

Data capability

The department fosters 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 drive improvements to our data governance arrangements, data asset discoverability, data sharing and data quality through our Data Strategy.

We work collaboratively with Commonwealth, state and territory, and non-government stakeholders to enhance the availability of, and access to, national health, disability and ageing data. We analyse this data appropriately to provide insights to decision makers.

In collaboration with a First Nations-led Working Group, we have developed a plan to implement a framework for the governance of Indigenous data over the next 5 years.

We aim to attract and retain data professionals across a range of data fields and lift data literacy across the department.

4 Jobs and Skills Australia, **Industries**, Jobs and Skills Australia, n.d, accessed June 2026

Evaluation

Our Evaluation Strategy 2023–26 provides a department-wide approach for consistent, robust and transparent evaluation of programs and policies. The Evaluation Strategy provides a clear framework to strengthen evaluation practice and culture across the department, and to embed the systematic use of evaluation evidence in decision-making, planning, and reporting. The department applies evaluation effort proportionately, aligning it to the size and risk of programs.

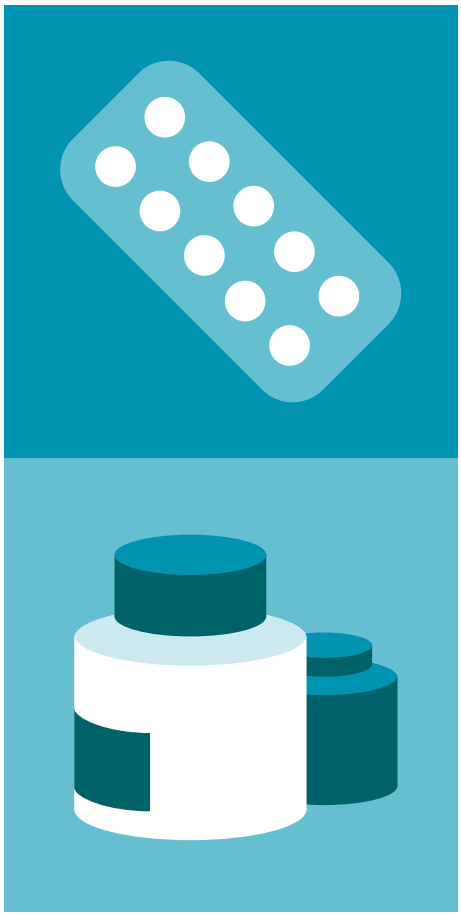
Financial management capability

The department is 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. Our strong financial management framework ensures we make evidence-based financial decisions and meet our financial accountability, performance and governance obligations.

We commissioned a sustainability review in 2025–26 to undertake a comprehensive assessment of the department's activities to provide a robust, evidence-based view of the functions, resourcing and configuration required to deliver agreed outcomes efficiently, effectively and sustainably over the forward estimates. We have centralised grants administration and implemented a procurement business partner model, building a more consistent and coordinated enterprise-wide approach that aligns with community expectations.

This includes:

- maturing policies, frameworks and standardised practices across grants and procurement
- strengthening governance arrangements and assurance mechanisms
- continuing targeted capability uplift across program, policy and operational teams
- embedding an evidence-based and practical approach to the safe, ethical and transparent use of generative AI, automation and digital technologies across grants and procurement, with appropriate oversight.



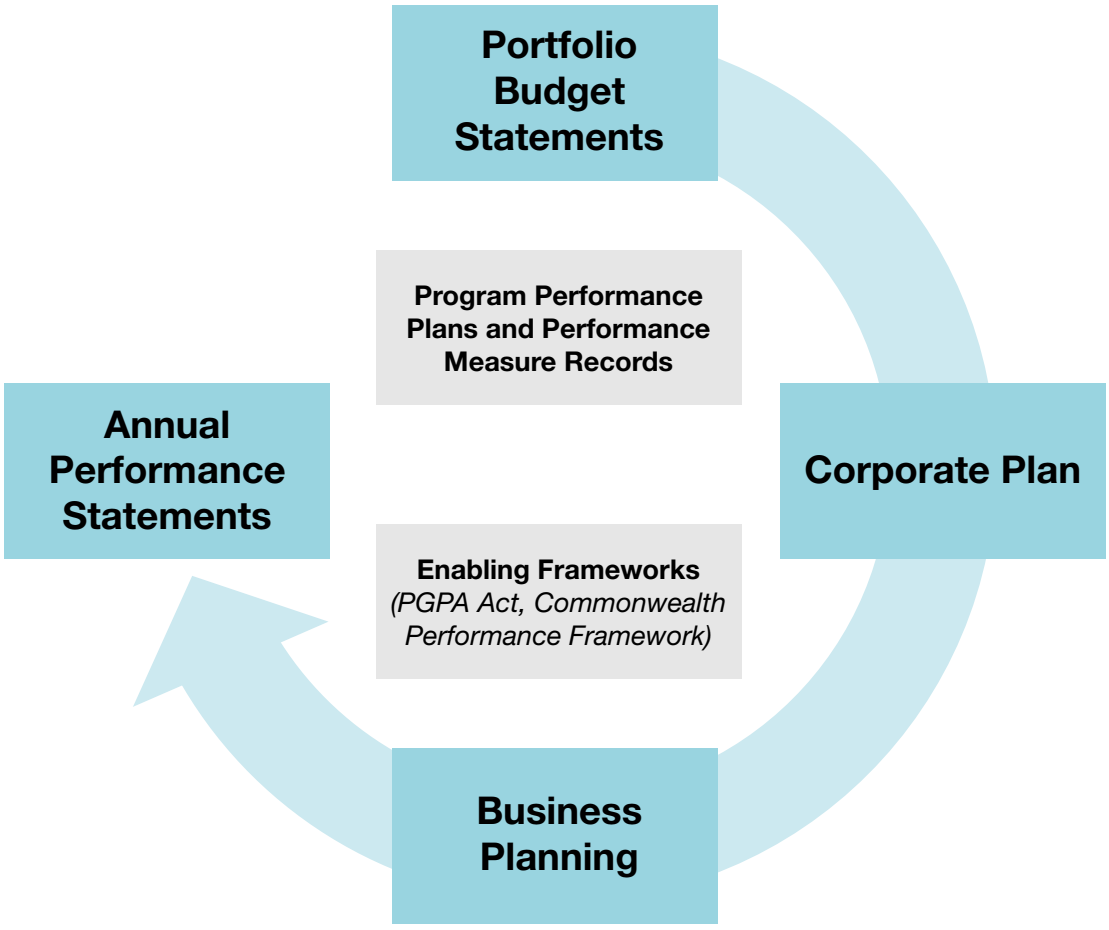
Our approach to performance

Our performance measurement and reporting framework supports effective measurement, monitoring and reporting of programs and policies. We assess our performance by measuring how we meet the objectives of our 21 Programs, and through them how we achieve our 4 Outcomes. The Corporate Plan links to our PB Statements, which outline the allocation of resources to achieving our purpose. The measurement and assessment of the performance measures outlined in our 2026–27 Corporate Plan will be published in our 2026–27 annual performance statements. This ensures our budget processes, business planning and performance measurement are aligned.

Performance assessment

We use an assessment scale to assess how our programs are delivering on their objectives. Each program sets an individual assessment scale for performance measurement. Targets are set and assessed against the following criteria:

- achieved
- substantially achieved (where applicable)
- not achieved.



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

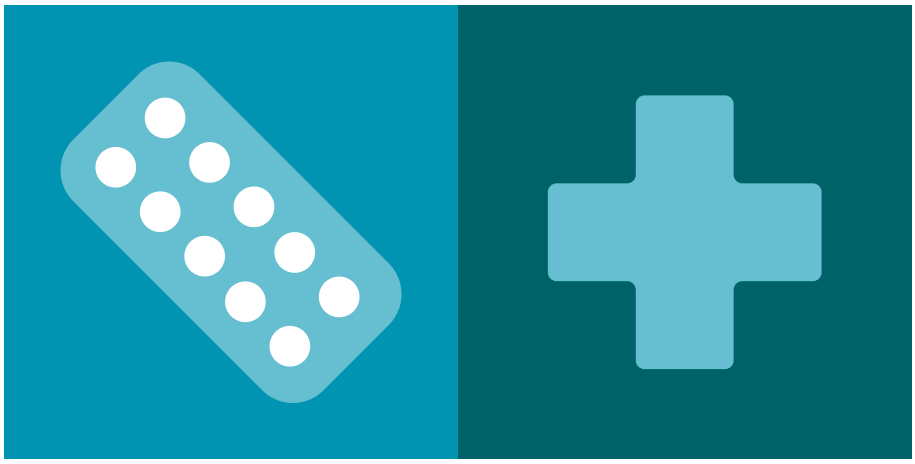
Program 1.5: Preventive Health and Chronic Disease Support

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: Health Research, Coordination and Access

This program contributes to Outcome 1 through ensuring sustainable funding for health services, and for research through the Medical Research Future Fund.

Key Activity 1.1A:

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

Performance Measure 1.1A:

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

Targets			
2026–27	**2027–28**	**2028–29**	**2029–30**
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.	a. Disburse at least 99% of MRFF funds available in 2029–30 towards grants of financial assistance. b. 100% of grants awarded in 2029–30 address one or more of the Australian Medical Research and Innovation Priorities in force at the time.

Assessment Scale for the 2026–27 target:

Achieved:

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.

Substantially achieved:

a. Disburse at least 94% of MRFF funds available in 2026–27 towards grants of financial assistance.

b. N/A.

Not achieved:

a. Disburse less than 94% of MRFF funds available in 2026–27 towards grants of financial assistance.

b. Less than 100% of grants awarded in 2026–27 address one or more of the Australian Medical Research and Innovation Priorities in force at the time.

Measure type:

Quantitative/Output

Target Rationale:

The legislated purpose of the MRFF is to provide grants of financial assistance to support research and innovation that contributes to improving the health and wellbeing of all Australians. To do this, the Medical Research Future Fund Act 2015 (MRFF Act) requires that funding decisions take in to account 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 funding from the MRFF is addressing the health priorities of Australians.

Data Source:

For a. the department sources data from the Administered Reporting Information by Program (ARIP) system under Priority 4 (the MRFF) in 2026–27.

For b. the department receives source data directly from the MRFF grant hubs, the National Health and Medical Research Council (NHMRC) and Business Grants Hub (BGH) through their online grants management systems.

Methodology:

For a. the department calculates reporting data using the sum of expenses for the MRFF under Priority 4 (MRFF Health Special Account) and the available MRFF budget under Priority 4 in the relevant financial year.

For Target b. each MRFF grant opportunity specifies which Australian Medical Research and Innovation Priorities it intends to address in the grant opportunity guidelines. The department uses application data provided by the NHMRC grant hub and BGH. These applications describe the health priorities the research will address if funded.

Measure owner:

Evidence and Research Division

Changes since 2026–27 Portfolio Budget Statements:

Minor updates to include ‘and innovation’ in the Key Activity and Performance Measure to improve clarity and ensure alignment with the MRFF Act. Updated program description to strengthen alignment and how it contributes to delivering Outcome 1.

Key Activity 1.1B:

Fund the National Blood Authority to provide a safe supply of blood, blood products and blood services, for the benefit of all Australians.

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.

Targets

2026–27	2027–28	2028–29	2029–30
Meet departmental funding set out in the National Supply Plan and Budget	Meet departmental funding set out in the National Supply Plan and Budget	Meet departmental funding set out in the National Supply Plan and Budget	Meet departmental funding set out in the National Supply Plan and Budget

Assessment Scale for the 2026–27 target:

Achieved: Meet departmental funding set out in the National Supply Plan and Budget

Substantially achieved: N/A

Not achieved: Funding set out in the National Supply Plan and Budget is not paid

Measure type:

Quantitative/Output

Target Rationale:

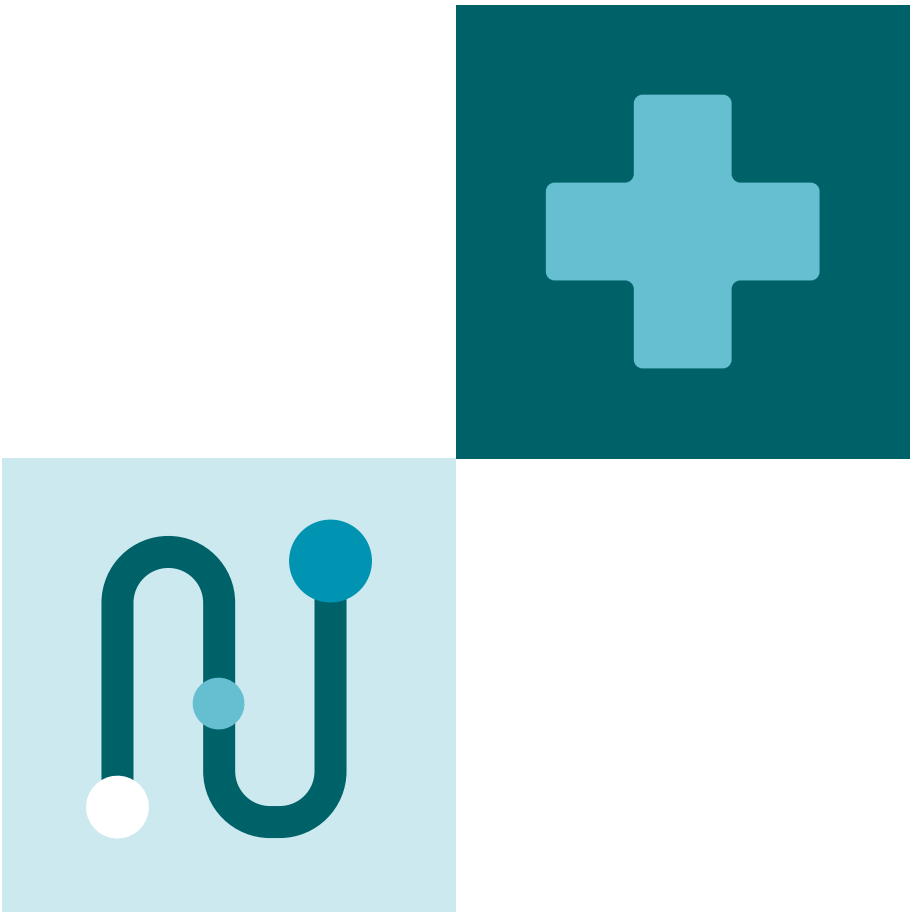
The level of funding provided for Program 1.1B varies according to program demand and is determined each year using the National Supply Plan and Budget (NSP&B), which is developed based on evidence-based reporting of previous annual requirements and then approved by all Health Ministers, as set out in the National Blood Agreement. Further information on the National Blood Agreement is available at **www.nba.gov.au**

Data Source:

The data source for 1.1B is collected, measured and reported from a number of sources. Information is sourced from:

- the department
- National Blood Authority (NBA)
- Lifeblood
- state and territory governments
- clinical advisory groups.

Methodology: The payment amount is based on the NSP&B. NSP&B estimates are based on previous actual expenditure, utilisation trends, agreed product price and the application of an agreed indexation rate, with the total split between jurisdictions. The NBA then engages with suppliers to develop price lists. The Commonwealth is consulted as part of the development of the NSPB and agrees the final amount, but does not contribute to the development of the estimates. The department pays its share (the target amount) accounting for reconciliation from the previous year.
Measure owner: Technology Assessment and Access Division
Changes since 2026–27 Portfolio Budget Statements: Updated program description to strengthen alignment and how it contributes to delivering Outcome 1. Introduced targets.



Program 1.2: Mental Health and Suicide Prevention

This program contributes to Outcome 1 through delivering evidence-based health policies and access to comprehensive and coordinated mental health care.

Key Activity 1.2A:

Facilitate access to services for mental health across the continuum of care.

Performance Measure 1.2A:

Number of mental health service contacts.

Targets			
2026–27	**2027–28**	**2028–29**	**2029–30**
No target	No target	No target	No target

Assessment Scale for the 2026–27 target:

Performance will be measured and assessed through three service components (*A, B* and *C*).

Measure type:

Quantitative/Output

Rationale for no target:

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

Performance will be reported in the context of broader mental health and suicide trends and overall service use across the mental health system.

Data Source:

Data for each component is drawn from established national administrative data collections.

- (components *A* and *B*) The Primary Mental Health Care Minimum Data Set (PMHC MDS) for Primary Health Network-commissioned services. The PMHC MDS provides the basis for Primary Health Networks 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.
- (component *C*) headspace Application Platform Interface (hAPI) dataset. The hAPI data set dataset supports data collection and reporting for services delivered through the national network of headspace centres.

Methodology:

The methodology for each component is:

- *(A)* Primary Health Network-commissioned service use based on the number of service contacts recorded in the PMHC MDS. Data is drawn from standard administrative reports and used to monitor service activity over time.
- *(B)* As per *(A)* for Medicare Mental Health Centre service contacts.
- *(C)* headspace service contacts for people aged 12-25 years based on aggregate administrative data provided by headspace National to monitor service activity over time.

Measure owner:

Mental Health and Suicide Prevention Division

Changes since 2026–27 Portfolio Budget Statements:

Updated program description to strengthen alignment and how it contributes to delivering Outcome 1. Updated Key Activity wording.

Key Activity 1.2B:

Facilitate access to suicide prevention initiatives.

Performance Measure 1.2B:

Number of service contacts for Universal Aftercare[5] services.

Targets			
2026–27	2027–28	2028–29	2029–30
No target	No target	No target	No target

Assessment Scale for the 2026–27 target:

Performance will be measured and assessed through the number of service contacts recorded in the Primary Mental Health Care Minimum Data Set (PMHC MDS).

Measure type:

Quantitative/Output

Rationale for no target:

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

Performance will be considered in the context of broader mental health and suicide trends and overall service use across the mental health system.

Data Source:

Service utilisation data sourced from the PMHC MDS for the Universal Aftercare program. The PMHC MDS provides the basis for Primary Health Networks 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:

Suicide prevention service use based on the number of service contacts recorded in the PMHC MDS. Data is drawn from standard administrative reports and used to assess service activity over time.

[5] 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.

Measure owner: Mental Health and Suicide Prevention Division
Changes since 2026–27 Portfolio Budget Statements: Updated program description to strengthen alignment and how it contributes to delivering Outcome 1. Updated Key Activity wording.

Program 1.3: First Nations Health

This program contributes to Outcome 1 through ensuring sustainable funding for health services and delivering evidence-based health policies.

Key Activity 1.3A:

Support Aboriginal Community Controlled Health Services (ACCHSs) to deliver primary health care services and community driven health initiatives.

Performance Measure 1.3A:

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

Targets			
2026–27	**2027–28**	**2028–29**	**2029–30**
Annual increase on 2025–26	Annual increase on 2026–27	Annual increase on 2027–28	Annual increase on 2028–29

Assessment Scale for the 2026–27 target:

Achieved: Annual increase on 2025–26
Substantially achieved: N/A
Not achieved: Decrease or remains same as 2025–26

Measure type:

Quantitative/Output

Target Rationale:

This target contributes to Aboriginal and Torres Strait Islander Community Controlled Health Care. The target aims to deliver a year-on-year increase in the portion of funding directed to ACCHSs, in line with Priority Reform 2 of the National Agreement on Closing the Gap. The IAHP was established to fund First Nations-led, culturally appropriate initiatives to increase access to health care and improve the health of Aboriginal and Torres Strait Islander people.

Targets have been forecast in line with ongoing commitment to, where appropriate:

- transitioning services delivered through non-indigenous organisations to ACCHSs
- supporting new entrants to the ACCHSs sector
- activities identified through the department's First Nations Health Funding Transition Program.[6]

[6] Available at: **First Nations Health Funding Transition Program (FNHFTP)**

Increased investment in ACCHSs provides Aboriginal and Torres Strait Islander people with the choice and opportunity to access ACCHSs and receive culturally appropriate health care.
Data Source: Financial data is sourced from the department's Administered Reporting Information by Program financial reporting system.
Methodology: The result is calculated using: **Numerator:** Expenditure to grant recipients classified as ACCHSs. **Denominator:** Total expenditure for the IAHP (Program 1.3).
Measure owner: First Nations Health Division
Changes since 2026–27 Portfolio Budget Statements: Updated program description to strengthen alignment and how it contributes to delivering Outcome 1. Revisions to Performance Measure, Key Activity and Target Rationale. Updated Aboriginal Community Controlled Health Organisations (ACCHOs) references to Aboriginal Community Controlled Health Services (ACCHSs) in line with departmental terminology preferences.

Key Activity 1.3B:

Support access to comprehensive, holistic health care.

Performance Measure 1.3B:

Increase the percentage of Aboriginal and Torres Strait Islander people attending Indigenous Australians' Health Programme (IAHP) funded services who have a current 715 health check.[7]

Targets			
2026	**2027**	**2028**	**2029**
Annual increase on 2025	Annual increase	Annual increase	Annual increase

Assessment Scale for the 2026–27 target:

Achieved: Annual increase on 2025
Substantially achieved: N/A
Not achieved: Decrease or remains same as 2025

Measure type:

Quantitative/Output

Target Rationale:

An annual Medicare Benefits Schedule 715 health check is available to all Aboriginal and Torres Strait Islander people. A 715 health check is considered current if it was completed within the past 12 months for children aged 0 to under 15 years, or within the past 24 months for people aged 15 and over. The 715 health check provides an entry point to comprehensive primary health care. This includes referral to targeted health initiatives supporting early intervention, prevention, chronic disease management and maternal and child health.

Targets have been determined based on past performance and calendar year trends, informed by current policy initiatives aimed at increasing uptake of 715 health checks.

Data Source:

Clinical activity data.

[7] 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**

Methodology:

The clinical activity source data is provided by health services through clinical information systems. This is submitted to the department through the Health Data Portal – data for Aboriginal and Torres Strait Islander people.

The result is calculated using:

Numerator: Number of regular clients who have a current 715 health check.

Denominator: Number of regular clients attending IAHP funded services.

Data is reported by calendar year.

Measure owner:

First Nations Health Division

Changes since 2026–27 Portfolio Budget Statements:

Updated program description to strengthen alignment and how it contributes to delivering Outcome 1. Revision to Performance Measure to reflect current health checks and Targets.

When the performance target was established, trend data showed a clear decline in health assessments during the COVID period, followed by a strong recovery in 2023 and 2024. Health assessment volumes have now returned to pre-COVID levels and the proportion of Aboriginal and Torres Strait Islander people attending IAHP funded services who have a current 715 health check has stabilised.

Program 1.4: Health Workforce

This program contributes to Outcome 1 through distribution of health workforce to enable access to comprehensive and coordinated health care.

Key Activity 1.4A:

Fostering a sustained growth of the health workforce.

Performance Measure 1.4A:

Annual change in headcount across the health workforce.

Targets

2026–27				2027–28	2028–29	2029–30
Location by Modified Monash Model (2023)	Number of Primary Care General Practitioners	Number of Nurses & Midwives	Number of Allied Health practitioners	Annual increase on 2026–27 and further increases for each subsequent year.	Annual increase on 2027–28 and further increases for each subsequent year.	Annual increase on 2028–29 and further increases for each subsequent year.
MM1 – Metropolitan	28,430	299,636	175,724			
MM2 – Regional centres	5,077	42,212	19,538			
MM3 – Large rural towns	4,276	31,158	14,131			
MM4 – Medium rural towns	2,950	14,180	7,134			
MM5 – Small rural towns	3,748	15,072	6,292			
MM6 – remote communities	1,091	4,257	1,662			
MM7 – Very remote communities	1,319	2,785	892			

Assessment Scale for the 2026–27 target:

Achieved: Each figure achieves 100% of its target.

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

Not achieved: Any figure achieves <95% of its target.

Measure type:

Quantitative/Output

Target Rationale:

The targets are based on 2024 figures and demonstrate the impact of a number of the program's activities under national strategies related to improving the planning for, quality and distribution of the Australian health workforce.

The targets seek 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 as classified by the Modified Monash Model.

Data Source:

Number of Primary Care General Practitioners: Medicare Benefits Schedule (MBS) dataset, Calendar Year 2024 (latest available) for 2026–27 figures. This administrative dataset capturing Medicare services is owned by the department in partnership with Services Australia.

Number of Nurses, Midwives and Allied Health Practitioners: National Health Workforce Dataset (NHWDS), 2024 (latest available) for 2026–27 figures. This dataset is comprised of practitioner registration and survey response information collected by the Australian Health Practitioner Regulation Agency 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[8]. The method uses elements from the MBS dataset to accurately count when, where and by what type of practitioner GP services are delivered. Providers may work in multiple locations, and are counted in each location they work in.

Headcounts for Nurses, Midwives and Allied Health Practitioners[9] 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.

Measure owner:

Workforce Division

[8] 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**

[9] 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.

Changes since 2026–27 Portfolio Budget Statements:

Updated program description to strengthen alignment and how it contributes to delivering Outcome 1. Update to include target figures based on 2025–26 result.

Key Activity 1.4B:

Distributing Primary Care General Practitioners to facilitate equitable access to health care.

Performance Measure 1.4B:

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

Targets

2026–27		2027–28	2028–29	2029–30
Location by Modified Monash Model (2023)	Primary Care GP FTE per 100,000 population	Annual increase on 2026–27 and further increases for each subsequent year.	Annual increase on 2027–28 and further increases for each subsequent year.	Annual increase on 2028–29 and further increases for each subsequent year.
MM1 – Metropolitan	111.4			
MM2 – Regional centres	111.8			
MM3 – Large rural towns	128.8			
MM4 – Medium rural towns	128.2			
MM5 – Small rural towns	80.6			
MM6 – Remote communities	67.6			
MM7 – Very remote communities	72.3			
Australia total	110.2			

Assessment Scale for the 2026–27 target:

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

Not achieved: Any figure achieves <95% of its target.

Measure type:

Quantitative/Output

Target Rationale:

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 primary care service delivery and facilitating access to the wider health care system.

The target projections consider:

1. The 2024 Supply and Demand Study for GPs[10] has a workforce projection model showing an undersupply of GPs over the next 25 years. The GP shortfall is further exacerbated by projections showing the departure rate of GPs from the workforce is outpacing the rate of new entrants. The analysis indicates Australia 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 Review[11] 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 targets demonstrate the department's commitment to drive and effectively implement into action key strategies and initiatives outlined in government policies.

Data Source:

Primary Care GP Full Time Equivalent (FTE): Medicare Benefits Schedule (MBS) dataset, Calendar Year 2024 (latest available) for 2026–27 figures. 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), 30 June 2024 (latest available granular data) for 2026–27 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.[12] 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 Modified Monash Model classifications.

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[10] Further information on the Supply and Demand Study for GPs can be found at: **hwd.health.gov.au/supply-and-demand/supply-demand-home.html**

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

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

Primary Care GP FTE per 100,000 population is then calculated as: 100,000 * GP FTE / Population.
Measure owner: Workforce Division
Changes since 2026–27 Portfolio Budget Statements: Updated program description to strengthen alignment and how it contributes to delivering Outcome 1. Update to include target figures based on 2025–26 result.

Key Activity 1.4C:

Training the next generation of Primary Care General Practitioners.

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.

Targets

2026–27		2027–28	2028–29	2029–30
Location by Modified Monash Model (2023)	Number of Primary Care General Practitioners FTE active training	Annual increase on 2026–27 and further increases for each subsequent year.	Annual increase on 2027–28 and further increases for each subsequent year.	Annual increase on 2028–29 and further increases for each subsequent year.
MM1 – Metropolitan	1,683.7			
MM2 - Regional centres	584.7			
MM3 - Large rural towns	460.7			
MM4 - Medium rural towns	339.2			
MM5 - Small rural towns	350.4			
MM6 - Remote communities	110.9			
MM7 - Very remote communities	75.4			
Australia total	3,605.1			

Assessment Scale for the 2026–27 target:

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

Measure type:

Quantitative/Output

Target Rationale:

The baseline performance levels report the full-time equivalent of doctors in active general practitioner (GP) training. Growing the number of doctors training to become GPs is a direct measure aimed at addressing current and projected GP shortages. Both the department and medical colleges are actively engaged to expand the awareness and benefits of a medical career in general practice. Delivery of GP training in regional, rural and remote locations, as well as metropolitan areas, is aimed at encouraging GPs to train in and then practice in those communities and helping to address maldistribution of the GP workforce.

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. This includes increased investment across the GP training pipeline, along with a requirement for at least 50% of training to occur outside metropolitan regions. Medical colleges have structured their medical training and mentor programs to accommodate doctors residing and working in regional and rural areas. An increase in targets will demonstrate that these government initiatives are working to increase training across all locations.

Data Source:

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

For AGPT and RGTS: GP Training Minimum Dataset (GPT MDS), Calendar Year 2024 (latest available complete data) for 2026–27 figures. 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. Data is provided twice per year, in April and October.

For RVTS: Program data submitted to the department in December 2024 for 2026–27 figures. 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 Modified Monash Model 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.

Measure owner:

Workforce Division

Changes since 2026–27 Portfolio Budget Statements:

Updated program description to strengthen alignment and how it contributes to delivering Outcome 1. Update to include target figures based on 2025–26 result.

Program 1.5: Preventive Health and Chronic Disease Support

This program contributes to Outcome 1 through delivering evidence-based health policies and access to comprehensive and coordinated preventive health care.

Key Activity 1.5A:

Deliver health promotion and education activities to support smoking and nicotine cessation and prevention.

Performance Measure 1.5A:

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

Targets			
2026–27	**2027–28**	**2028–29**	**2029–30**
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%

Assessment Scale for the 2026–27 target:

Achieved: Decrease on 2025–26 result towards <5%
Substantially achieved: N/A
Not achieved: Increase or same result as 2025–26

Measure type:

Quantitative/Output

Target Rationale:

The target aligns with the National Preventive Health Strategy 2021–2030 (NPHS)[13] and the National Tobacco Strategy 2023–2030 (NTS)[14] commitments to achieving a national daily smoking prevalence for adults (≥18 years) of less than 5% by 2030.

Data Source:

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

[13] 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**

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

Methodology: Daily smoking prevalence reported through HILDA among adults aged ≥18 years.
Measure owner: Population Health Division
Changes since 2026–27 Portfolio Budget Statements: Updated program description to strengthen alignment and how it contributes to delivering Outcome 1.

Key Activity 1.5B:

Facilitate access to alcohol and other drug treatment services.

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.

Targets

2026–27	2027–28	2028–29	2029–30
a. All grant agreements executed on time. b. Treatment service providers meet their identified key performance indicators.	a. As per 2026–27 b. As per 2026–27	a. As per 2026–27 b. As per 2026–27	a. As per 2026–27 b. As per 2026–27

Assessment Scale for the 2026–27 target:

Achieved:

a. 100%

b. 100%

Substantially achieved:

a. 90 to 99.9%

b. 90 to 99.9%

Not achieved:

a. <90%

b. <90%

Measure type:

Quantitative/Output

Target Rationale:

a. The timely execution of grants with alcohol and other drug treatment service providers supports patient access to these services.

b. Ensuring that expected contractual key performance indicators are met supports the delivery of treatment services provided.

Data Source:

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

b. The Grant Payment System 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.

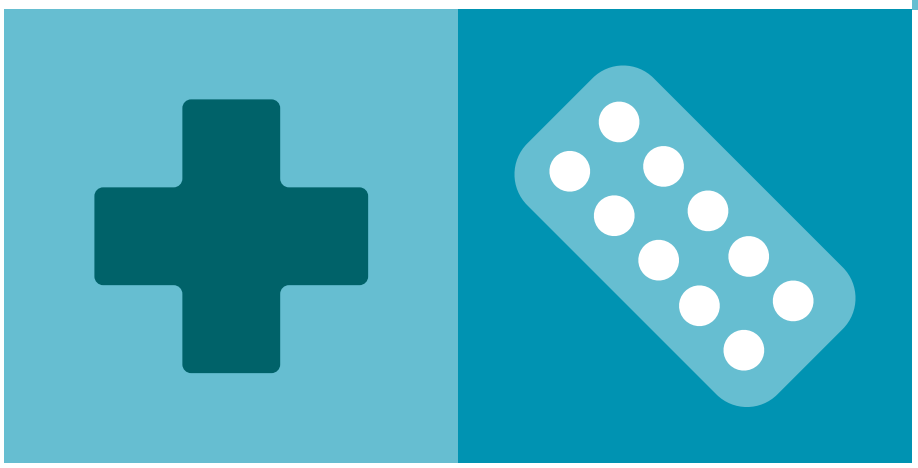
b. Calculate the number of service providers meeting their key performance indicators/the total number of service providers, and report as a percentage.

Measure owner:

Population Health Division

Changes since 2026–27 Portfolio Budget Statements:

Updated program description to strengthen alignment and how it contributes to delivering Outcome 1.



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.

Performance Measure 1.5C:

Administer the 3 cancer screening programs:

a. National Bowel Cancer Screening Program.

b. National Cervical Screening Program.

c. National Lung Cancer Screening Program.

Targets			
2026–27	**2027–28**	**2028–29**	**2029–30**
1. Correspondence sent (pre/invitations) of correspondence due to be sent (%) – 100% (a., b., c.) 2. Bowel test kits sent of kits due to be sent (%) – 100% (a.) 3. Follow up contacts made of contacts due to be made (%) - 100% (a., b., c.)	As per 2026–27	As per 2027–28	As per 2028–29

Assessment Scale for the 2026–27 target:

Achieved:

1. Correspondence sent/due to be sent 100% (a., b., c.)
2. Bowel test kits sent/due to be sent 100% (a.)
3. Follow up contacts made/due to be made 100% (a., b., c.)

Substantially achieved:

1. Correspondence sent/due to be sent 97% to <100% (a., b., c.)
2. Bowel test kits sent/due to be sent 97% to <100% (a.)
3. Follow up contacts made/due to be made 97% to <100% (a., b., c.)

Not achieved:

1. Correspondence sent/due to be sent <97% (a., b., c.)
2. Bowel test kits sent/due to be sent <97% (a.)
3. Follow up contacts made/due to be <97% (a., b., c.)

Measure type:

Quantitative/Output

Target Rationale:

The targets reflect operational output performance targets of the National Cancer Screening Register in delivering the programs.

The targets for '**achieved'** are stretch targets based on pre-existing program targets.

The targets for '**substantially achieved'** represent current expected performance and opportunity for improvement.

The targets for '**not achieved'** represent the levels of operational performance that would be considered to require remediation.

Data Source:

Data for this measure is operational correspondence and follow up data, extracted from the National Cancer Screening Register (NCSR), and is not available to the public due to privacy constraints.

Methodology:

Correspondence (pre/invitations) sent of correspondence due to be sent (%)

- Correspondence (pre-invites and invitations) due to be sent:
    - All correspondence (pre-invites and invitations) interventions scheduled as due by the NCSR (triggered) during the reporting period.
- Correspondence sent:
    - The NCSR has received notification from the mailhouse (physical letter), Communications API (email) or Whisper (SMS) that the correspondence has been sent.
- The count is of all correspondence, not people.
- People can have multiple interventions within a reporting period.
- Excludes any correspondence triggered for people who are determined to be not eligible or uncontactable, after the intervention is triggered.
- Not eligible includes:
    - deceased people

- people who deferred
- people who opted out
- people excluded by Medicare
- for a. National Bowel Cancer Screening Program (NBCSP) people with a positive colonoscopy exclusion alert
- for b. National Cervical Screening Program (NCSP) Cancer, Hysterectomy alerts
- for c. National Lung Cancer Screening Program (NLCSP) Cancer, low-dose computed tomography (LDCT) unsuitable alerts.

- Uncontactable includes:
  - people without a valid mailing address for physical correspondence
  - people without a valid mobile phone number for SMS correspondence
  - people without a valid email address for email correspondence.

Bowel test kits sent of kits due to be sent (%)

- Bowel test kits due to be sent:
  - All bowel test kit interventions scheduled as due by the NCSR (triggered) during the reporting period.
- Bowel test kits sent:
  - The NCSR has received notification from mailhouse (physical letter) that the correspondence has been sent.
- The count is of all bowel test kit interventions, not people.
- People can have multiple interventions within a reporting period, and multiple kits.
- Excludes any correspondence triggered for people who are determined to be not eligible or uncontactable, after the intervention is triggered.
- Not eligible includes:
  - deceased people
  - people who deferred
  - people who opted out
  - people excluded by Medicare
  - for a. NBCSP people with a positive colonoscopy exclusion alert.
- Uncontactable includes:
  - people without a valid mailing address for physical correspondence.

Definition for Follow-up contacts made of contacts due to be made (%)

- Follow-up contacts due to be made:

- All follow-up interventions scheduled as due by the NCSR (triggered) during the reporting period

- Follow-up contact made:
  - The NCSR has received notification from mailhouse (physical letter), Communications API (email) or Whisper (SMS) that the contact has been made for correspondence. Phone call confirmed as complete by completion of the appropriate form.
- The count is of all follow-up contact, not people.
- People can have multiple interventions within a reporting period.
- Excludes any follow-up contact triggered for people who are determined to be not eligible or uncontactable, after the intervention is triggered.
- Not eligible includes:
  - deceased people
  - people who deferred
  - people who opted out
  - people excluded by Medicare
  - for a. NBCSP people with a positive colonoscopy exclusion alert
  - for b. NCSP Cancer, Hysterectomy alerts
  - for c. NLCSP Cancer, LDCT unsuitable alerts.
- Uncontactable includes:
  - people with an invalid mailing address for physical correspondence
  - people without a valid mobile phone number for SMS correspondence
  - people without a valid email address for email correspondence
  - people without a healthcare provider (HCP) listed for follow-up to HCPs or HCPs with an invalid mailing address.

Measure owner:

Chronic Conditions and Screening Division

Changes since 2026–27 Portfolio Budget Statements:

Updated program description to strengthen alignment and how it contributes to delivering Outcome 1.

Program 1.6: Primary Health Care Quality and Coordination

This program contributes to Outcome 1 through improved access to comprehensive and coordinated primary health care.

Key Activity 1.6A:

Supporting Primary Health Networks (PHNs) to increase the efficiency, effectiveness, accessibility, and quality of primary health care services through health system coordination and building capacity in the primary care sector.

Performance Measure 1.6A:

PHNs are meeting delivery objectives in supporting general practice.

Targets

2026–27	2027–28	2028–29	2029–30
3 Case studies demonstrate performance: - Murray PHN - North Western Melbourne PHN - North Sydney PHN	Case studies demonstrate performance	TBA[15]	TBA[16]

Assessment Scale for the 2026–27 target:

Performance for 2026–27 will be assessed through 3 case studies on PHNs support for general practices in their region.

Measure type:

Qualitative/Effectiveness

Target Rationale:

PHNs deliver activities across three core areas – coordination, capacity-building and commissioning. Central to their role is support to general practices, a function that PHNs have delivered since their inception. Supporting general practices both builds capacity in delivering health services to the community and facilitates coordination between GPs and other parts of the health and aged care systems.

15 Reporting from 2028–29 will transition to measures from the PHN Performance Measurement and Reporting Framework.
16 Ibid.

Metropolitan:

PHNs that include a major metropolitan area often support a larger number of general practices and a greater proportion of large practices. Challenges for metropolitan GPs include larger patient volumes, higher operational costs, such as rental rates and workforce costs, and a patient cohort with more complex chronic disease and mental health concerns.

Regional and Remote:

PHNs in regional and remote locations typically support fewer general practices but face the challenge of much greater distances between practices. Some of the key concerns for general practices in regional and remote locations are workforce shortages, a lack of access to allied health and specialists and financial barriers to care for patients.

Higher and lower base rates of general practice accreditation compared to the national average rate:

Eligible general practices can seek accreditation against standards, which PHNs promote as part of their support for general practices. However, PHNs face different challenges in promoting higher accreditation rates, including practice turnover (typically higher in metropolitan areas), practice size (smaller practices are less likely to be accredited) and access to support staff such as practice managers. These challenges and PHNs' responses will be considered as part of the case studies.

Data Source:

The main data source will be qualitative information supplied by PHNs on their activities to support general practice. This information will be supported by practice accreditation rates and quality improvement data submitted by general practices to PHNs through the Practice Incentives Program Quality Improvement Incentive scheme.

Methodology:

Through an evaluative approach we will seek to understand how effectively 3 PHNs supported general practices in their region. The three PHNs selected for case study analysis are:

1. Murray PHN

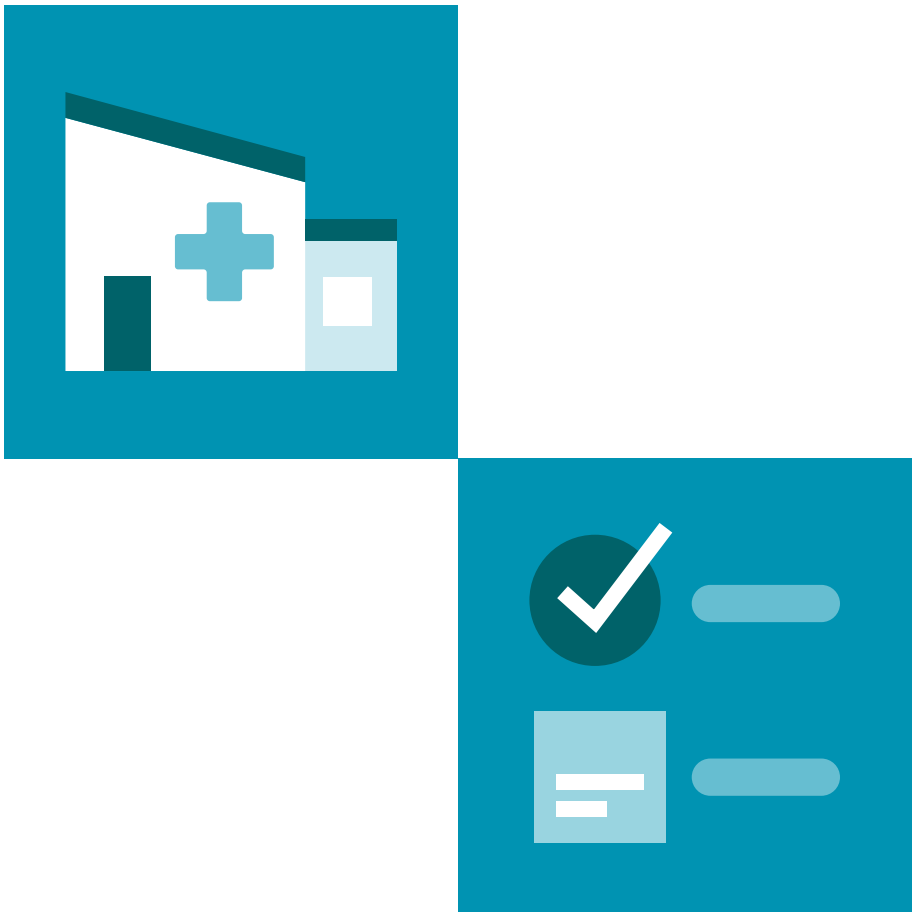
   A Regional location with a consistently high and improving accreditation rate, from 88.1% in 2019–20 to 98.0% in 2024–25 (compared with the national rates of 79.7% in 2019–20 and 85.9% in 2024–25)

2. North Western Melbourne PHN

   A Metro location with a lower accreditation rate of 78.7% in 2024–25. While rates have been increasing, accreditation is consistently below the overall national rate.

3. North Sydney PHN

A Metro location that has recently achieved a high accreditation rate of 97.3% in 2024–25 (compared with 75.9% in 2023–24).
Measure owner: Primary Care Division
Changes since 2026–27 Portfolio Budget Statements: Updated program description to strengthen alignment and how it contributes to delivering Outcome 1. Updates to the key activity, performance measure and targets to reflect assessment of qualitative effectiveness of PHNs through case studies.



Key Activity 1.6B:

Support state and territory governments and PHNs to deliver Medicare Urgent Care Clinics (UCCs).

Performance Measure 1.6B:

Number of Medicare UCC presentations that report they otherwise would have gone to an Emergency Department (ED) or called an ambulance if the Medicare UCC was not available.

Targets			
2026–27	**2027–28**	**2028–29**	**2029–30**
Increase on 2025–26 baseline	Increase on 2026–27	Increase on 2027–28	Increase on 2028–29

Assessment Scale for the 2026–27 target:

Achieved: Increase on 2025–26 baseline

Substantially achieved: N/A

Not achieved: A decrease or remains same as 2025–26 baseline result

Measure type:

Quantitative/Output

Target Rationale:

The target for this metric is an increase on the 2025–26 baseline performance of the existing 76 Medicare UCCs that report data about where a patient would have otherwise gone (module data).

There are a total of 137 Medicare UCCs operating as at 17 June 2026. The 50 opened during 2025–26 will be excluded from the baseline figure in their establishment year as most were not operational until December 2025, which would not provide a full year baseline.

The increased targets in the following years will be proportional to the number of Medicare UCCs that have this data available.

Data Source:

Data is sourced from the Medicare UCCs dataset within Health's Enterprise Data Warehouse and includes responses from patients who answered the Medicare UCC Module question: 'Where would the patient have gone if the Medicare UCC was not available?' with either 'local ED' or 'ambulance'.

The Medicare UCC Module forms the basis of the Medicare UCC Dataset. This module is completed daily by participating Medicare UCCs, with data collected weekly by a third-party provider on behalf of the department and securely stored within the department.

Data extraction is limited to patients who have consented to share their deidentified information with the department, and to Medicare UCCs with compatible IT systems where the Module is installed. As a result, the dataset currently excludes 5 Australian Capital Territory (ACT) clinics and 6 remote Northern Territory (NT) clinics.
Methodology: The relevant question in the Medicare UCC Module is: 'Where would the patient have gone if the Medicare UCC was not available?' Patients are provided with seven response options: 'ambulance', 'general practitioner', 'local ED', 'other health professional', 'telephone or virtual triage service (e.g. Healthdirect)', 'would not have sought medical care', or 'other'. To report on the performance measure, the department extracts and collates the combined number of responses of 'local ED' and 'ambulance' from the Medicare UCC dataset within the department's Enterprise Data Warehouse. This extraction is limited to clinics where patients have consented to share their de-identified data and where the Medicare UCC Module is installed. The department extracts and collates the combined number of 'local ED' and 'ambulance' responses from the Medicare UCC dataset in the department's Enterprise Data Warehouse for clinics where the patient has consented to share their deidentified data with the department and the Medicare UCC Module is installed (currently excludes 5 ACT nurse led and 6 remote NT clinics).
Measure owner: Primary Care Division
Changes since 2026–27 Portfolio Budget Statements: Updated program description to strengthen alignment and how it contributes to delivering Outcome 1. Updated targets to reflect an increase on the 2025–26 baseline.

Program 1.7: Primary Care Practice Incentives and Medical Indemnity

This program contributes to Outcome 1 through access to comprehensive and coordinated health care through incentive payments to eligible general practices.

Key Activity 1.7A:

Providing Practice Incentives Program (PIP) payments to eligible general practices.

Performance Measure 1.7A:

The percentage of general practices accredited under the National General Practice Accreditation (NGPA) Scheme participating in PIP.

Targets			
2026–27	2027–28	2028–29	2029–30
≥95.0%	≥95.0%	≥95.0%	≥95.0%

Assessment Scale for the 2026–27 target:

Achieved: ≥95.0%

Substantially achieved: ≥93.5% to 94.9%

Not achieved: <93.4%

Measure type:

Quantitative/Output

Target 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 2029–30 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.

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.

Measure owner:

Primary Care Division

Changes since 2026–27 Portfolio Budget Statements:

Updated program description to strengthen alignment and how it contributes to delivering Outcome 1.

Program 1.8 Health Protection, Emergency response and Regulation

This program contributes to Outcome 1 through protecting the health and safety of the Australian community through regulatory oversight.

Key Activity 1.8A:

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

Performance Measure 1.8A:

Percentage of therapeutic goods evaluations that meet statutory timeframes.

Targets			
2026–27	2027–28	2028–29	2029–30
100%	100%	100%	100%

Assessment Scale for the 2026–27 target:

Achieved: 100%
Substantially achieved: N/A
Not achieved: <100%

Measure type:

Quantitative/Output

Target Rationale:

The target for evaluating therapeutic goods within statutory timeframes is 100%. This reflects the commitment of the Therapeutic Goods Administration (TGA) to meeting statutory timeframes as defined under the *Therapeutic Goods Act 1989*. Transparent reporting builds public trust and confidence in the TGA's performance of its regulatory functions.

Further information on the broader performance of the TGA is available in its annually published Performance Reports.[17]

Data Source:

Data for this measure is sourced from internal systems, tracking evaluation start and completion dates. Data is analysed and maintained internally by the department.

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

Methodology:

The 6 TGA program areas contributing to this measure are those that conduct evaluations under statutory timeframes. They calculate the total number of evaluations that met statutory timeframes as a proportion of the total number of evaluations completed, as defined for that program.

The data for the reporting period is then converted into a percentage. The specific performance measure is calculated using the total number of evaluations completed within the statutory timeframe (**numerator**) divided by the total number of evaluations subjected to the statutory timeframe (**denominator**).

Measure owner:

Health Products Regulation Group (Therapeutic Goods Administration)

Changes since 2026–27 Portfolio Budget Statements:

Updated program description to strengthen alignment and describe how it contributes to delivering Outcome 1.

Key Activity 1.8B:

Ensuring compliance and monitoring of regulated entities through completing inspections under the *Narcotic Drugs Act 1967*.

Performance Measure 1.8B:

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

Targets			
2026–27	**2027–28**	**2028–29**	**2029–30**
≥35	≥36	≥36	≥36

Assessment Scale for the 2026–27 target:

Achieved: ≥35

Substantially achieved: ≥33 to 34

Not achieved: <33

Measure type:

Quantitative/Output

Target Rationale:

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

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

Performance targets have been set to align with actual observed performance trends. These trends are based on the ODC's risk matrix and the resources available to conduct inspections under the *Narcotic Drugs Act 1967*.

Data Source:

Data for the reporting period is sourced from the internal Inspection Schedule and finalised inspection reports maintained by the ODC.

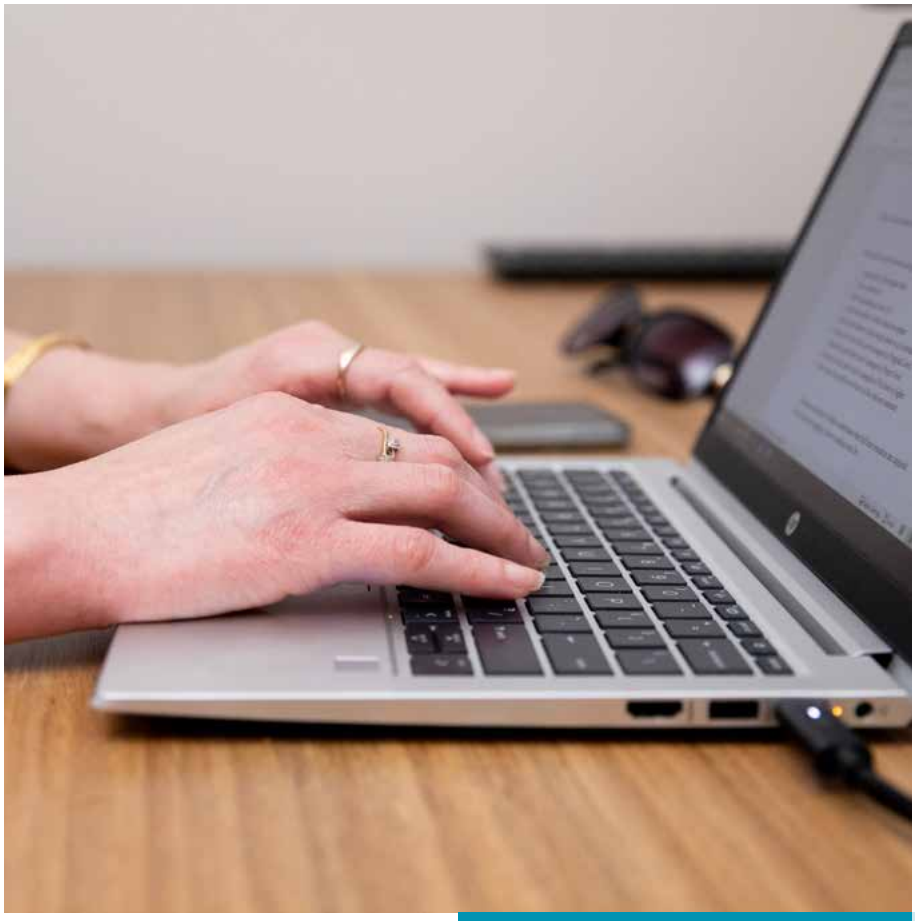
Methodology:

Data is extracted from the Inspection Schedule to determine the number of inspections completed within the reporting period.

An inspection is considered complete once the inspection activity has occurred and the inspection outcome report has been provided to the licence holder.

The Inspection Schedule records forecast and completed inspections and documents when an inspection report is finalised.

Measure owner: Office of Drug Control
Changes since 2026–27 Portfolio Budget Statements: Updated program description to strengthen alignment and describe how it contributes to delivering Outcome 1.



Key Activity 1.8C:

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

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.

Targets			
2026–27	**2027–28**	**2028–29**	**2029–30**
a. ≥98% b. ≥98%	a. ≥98% b. ≥98%	a. ≥98% b. ≥98%	a. ≥98% b. ≥98%

Assessment Scale for the 2026–27 target:

Achieved:
a. ≥98%
b. ≥98%

Substantially achieved:
a. ≥95%
b. ≥95%

Not achieved:
a. <95%
b. <95%

Measure type:

Quantitative/Output

Target Rationale:

The Gene Technology Legislation does not prescribe limits on the number or timing of applications. The performance target of ≥98% allows flexibility to manage fluctuations in application volume and operational pressures, including in periods of increased demand or emerging compliance issues.

A target of 100% is not considered achievable due to the inherent complexity of GMO application assessments and the potential for unforeseen factors to arise. These may include the assessment of novel modifications or the need to seek additional information, each of which can impact decision timeframes. Accordingly, targets have been established at realistic levels, informed by historical performance data, risk considerations, operational capacity, and the volume of active licences that may require variation.

Data Source:

Data for this measure is sourced from the Office of the Gene Technology Regulator's (OGTR) internal systems which track:

- evaluation start and completion dates to ensure alignment with statutory requirements for measure (a.)
- assessment of incidents of non-compliance with licence conditions for measure (b.).

Data is analysed and maintained internally by the department.

Methodology:

Application records are analysed to determine if decisions were made within applicable statutory timeframes.

Application data within the reporting period is converted into a percentage based on the total number of decisions made within statutory timeframes (**numerator**) divided by the total number of decisions subject to statutory timeframes (**denominator**). Incident records are analysed to determine whether reports or allegations of non-compliance were assessed within the period.

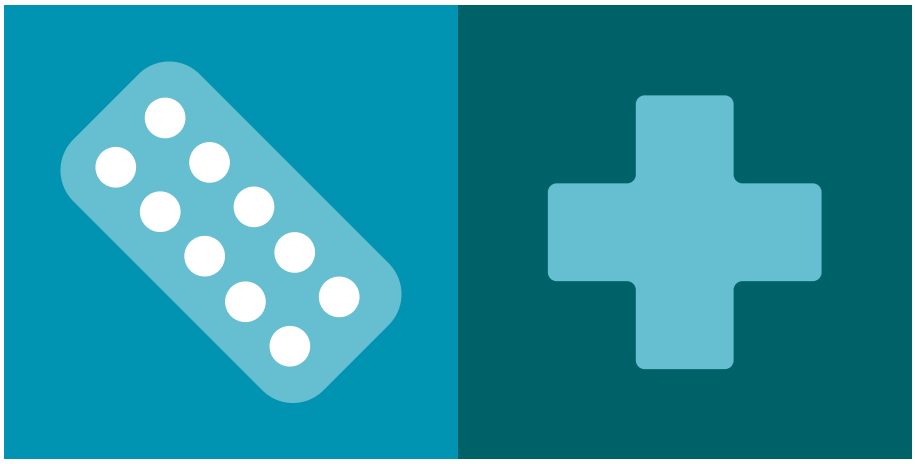
Incident data is converted into a percentage based on the total number of alleged incidents of non-compliance with authorisation conditions that were assessed (**numerator**) divided by the total number of GMO authorisation related incidents received (**denominator**).

Measure owner:

Office of the Gene Technology Regulator

Changes since 2026–27 Portfolio Budget Statements:

Minor updates to wording for clarity. Updated program description to strengthen alignment and describe how it contributes to delivering Outcome 1.



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.

Performance Measure 1.8D:

Proportion of industrial chemical risk assessments completed within statutory timeframes.

Targets			
2026–27	2027–28	2028–29	2029–30
100%	100%	100%	100%

Assessment Scale for the 2026–27 target:

Achieved: 100%
Substantially achieved: N/A
Not achieved: <100%

Measure type:

Quantitative/Output

Target Rationale:

The target for completing industrial chemical risk assessments within statutory timeframes has been set at 100%. This target reflects the obligations of the Australian Industrial Chemicals Introduction Scheme (AICIS) under the *Industrial Chemicals Act 2019* and its historical performance.

AICIS publishes risk assessment timeframes on its website.[18] Transparent reporting against this target builds public trust and confidence in AICIS's regulatory functions and enables industry to make informed decisions and plan with confidence.

For the 2026–27 reporting period, AICIS' performance target has increased from 95% to 100%, to better align with obligations under the *Industrial Chemicals Act 2019*.

Data Source:

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

[18] Available at: **www.industrialchemicals.gov.au**

Methodology:

To determine the result, the following calculation is applied:

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

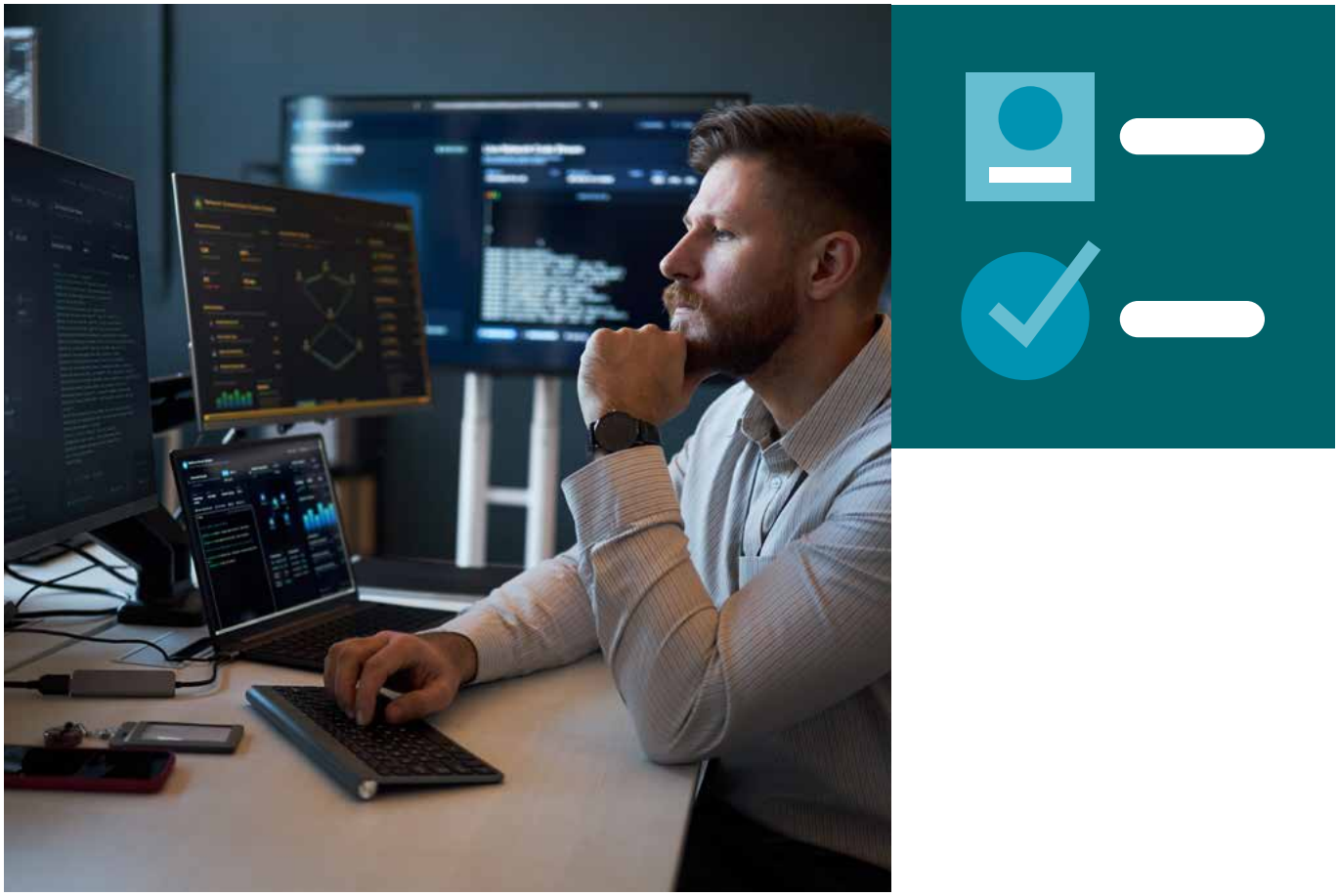
$$Result = \frac{a_{completed\ within\ timeframe} + b_{completed\ within\ timeframe} + c_{completed\ within\ timeframe}}{a_{total\ completed} + b_{total\ completed} + c_{total\ completed}}$$

Measure owner:

Australian Industrial Chemical Introduction Scheme

Changes since 2026–27 Portfolio Budget Statements:

Updated program description to strengthen alignment and describe how it contributes to delivering Outcome 1 and target to reflect 100%.



Program 1.9 Immunisation

This program contributes to Outcome 1 through protecting the health and safety of the Australian community through the National Immunisation Program.

Key Activity 1.9A:

Increase immunisation coverage rates by implementing the National Immunisation Program.

Performance Measure 1.9A:

Immunisation coverage rates:

a. For children at 5 years of age are increased and maintained at the protective rate of 95.00%.

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 maintained.

c. For 15-year-olds, HPV vaccinations are increased with a target of 90.00% coverage by 2030.

Targets

2026–27	2027–28	2028–29	2029–30
a. ≥95.00% b. Progressive increase towards ≥95.00% c. Progressive increase towards ≥90.00%	a. ≥95.00% b. Progressive increase towards ≥95.00% c. Progressive increase towards ≥90.00%	a. ≥95.00% b. Progressive increase towards ≥95.00% c. Progressive increase towards ≥90.00%	a. ≥95.00% b. Progressive increase towards ≥95.00% c. Progressive increase towards ≥90.00%

Assessment Scale for the 2026–27 target:

Achieved:

a. 95.00%

b., c. Increase on 2025–26 results

Substantially achieved:

a., b., c. N/A

Not achieved:

a., b., c. Decrease or same result as 2025–26

Measure type:

Quantitative/Output (Proxy for Effectiveness)

Target Rationale:

The target is set at 95.00% 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 target for human papillomavirus (HPV) vaccinations among 15-year-olds is set at 90.00% by 2030, aligning with the National Strategy for the Elimination of Cervical Cancer in Australia. 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:

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 receiving HPV vaccinations in the AIR.

Measure owner:

Health Security and Immunisation Division

Changes since 2026–27 Portfolio Budget Statements:

Minor update to the performance measure wording. Updated program description to strengthen alignment and how it contributes to delivering Outcome 1.

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: Medical Benefits

This program contributes to Outcome 2 by ensuring access to cost-effective and affordable medical services through the Medicare Benefits Schedule.

Key Activity 2.1A:

Provide access to subsidised health services.

Performance Measure 2.1A:

Percentage of Australians accessing Medicare Benefits Schedule services.

Targets			
2026–27	2027–28	2028–29	2029–30
>87%	>87%	>87%	>87%

Assessment Scale for the 2026–27 target:

Achieved: >87%

Substantially achieved: 85% to 87%

Not achieved: <85%

Measure type:

Quantitative/Output (Proxy for Effectiveness)

Target Rationale:

The Medicare Benefits Schedule (MBS) aims to support eligible Australian residents and eligible visitors to access high quality and affordable health care. The target of >87% demonstrates that the MBS provides access to subsidised services at a level that is equivalent to historical levels.

Any significant deviation from >87% 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 target 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.

Data Source:

Medicare claims data is sourced directly from Services Australia which processes Medicare claims on behalf of the department.

Two data sources inform this measure:

1. The number of people accessing MBS services is calculated using Medicare claims data.

2. The Estimated Resident Population (ERP) from the Australian Bureau of Statistics, National, state and territory population, Excel workbook "Population – states and territories", Sheet "Data1", Column: Estimated Resident Population: Persons: Australia", ERP as at 30 June 2026.[19]

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 calculated is used. For the 2026–27 measure this will be the ERP as at 30 June 2026.

The **numerator** is divided by the **denominator** to calculate the proportion of people with at least one Medicare service processed in the reporting period.

Measure owner:

Medicare Benefits and Digital Health Division

Changes since 2026–27 Portfolio Budget Statements:

The targets have been adjusted to reflect the expected reduction in demand. Reductions in demand for MBS services may result from patients accessing care through other health professionals (e.g. obtaining clinical certificates for work absences from pharmacists or accessing clinical services through pharmacy-led trials in some states).

Additionally, services not funded under the MBS may be accessed through privately funded providers (e.g. online clinics), or through other government programs (e.g. Department of Veterans' Affairs). Reductions in demand for Medicare services due to these factors would be anticipated to increase in the future, as the government is undertaking work to support scope of practice reform.

Updated program description to strengthen alignment and how it contributes to delivering Outcome 2.

[19] Available at: **https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release**. Accessed, July 2026.

Key Activity 2.1B:

Support patient access to Medicare-subsidised General Practitioner services.

Performance Measure 2.1B:

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

Targets			
2026–27	**2027–28**	**2028–29**	**2029–30**
>80%	>80%	>80%	>80%

Assessment Scale for the 2026–27 target:

Achieved: >80%

Substantially achieved: 78% to 80%

Not achieved: <78%

Measure type:

Quantitative/Output

Target Rationale:

The target of >80% demonstrates the program is providing support for Australians to receive primary care services, which are more effective and cost-effective than other acute or emergency 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.

Data Source:

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

1. The number of eligible Australian residents and visitors who had a GP Non-Referred Attendance is calculated using Medicare claims data.

2. The Estimated Resident Population (ERP) from the Australian Bureau of Statistics, National, state and territory population, Excel workbook "Population – states and territories", Sheet "Data1", Column: Estimated Resident Population: Persons: Australia", ERP as at 30 June 2026.[20]

[20] Available at: **www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release**

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 calculated is used. For the 2026–27 measure this will be the ERP as at 30 June 2026.

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.

Measure owner:

Medicare Benefits and Digital Health Division

Changes since 2026–27 Portfolio Budget Statements:

The targets have been adjusted to reflect the expected reduction in demand. Reductions in demand for services may result from patients accessing care through other health professionals (e.g. obtaining clinical certificates for work absences from pharmacists or accessing clinical services through pharmacy-led trials in some states).

Additionally, services not funded under the MBS may be accessed through privately funded providers (e.g. online clinics), or through other government programs (e.g. Department of Veterans' Affairs). Reductions in demand for Medicare services due to these factors would be anticipated to increase in the future, based on current trends.

Updated program description to strengthen alignment and how it contributes to delivering Outcome 2.

Key Activity 2.1C:

Support access to bulk billed General Practice attendances.

Performance Measure 2.1C:

General Practice Non-Referred attendance bulk-billing rate.

Targets			
2026–27	**2027–28**	**2028–29**	**2029–30**
>80.8%	Annual increase on 2026–27 and further increases for each subsequent year.	Annual increase on 2026–27 and further increases for each subsequent year.	Annual increase on 2026–27 and further increases for each subsequent year.

Assessment Scale for the 2026–27 target:

Achieved: >80.8%

Substantially achieved: 79.8% to 80.8%

Not achieved: <79.8%

Measure type:

Quantitative/Output

Target Rationale:

The national General Practice Non-Referred attendance bulk-billing rate for the year to date of July 2025 to April 2026 is 80.3%. Based on last year's trend, 0.5% points have been added to adjust for the months of May and June. The government has expanded General Practice bulk-billing incentive eligibility to cover all Medicare eligible patients from November 2025. This has reduced financial barriers for patients.

Data Source:

Medicare claims data is sourced directly from Services Australia which processes Medicare claims on behalf of the department.

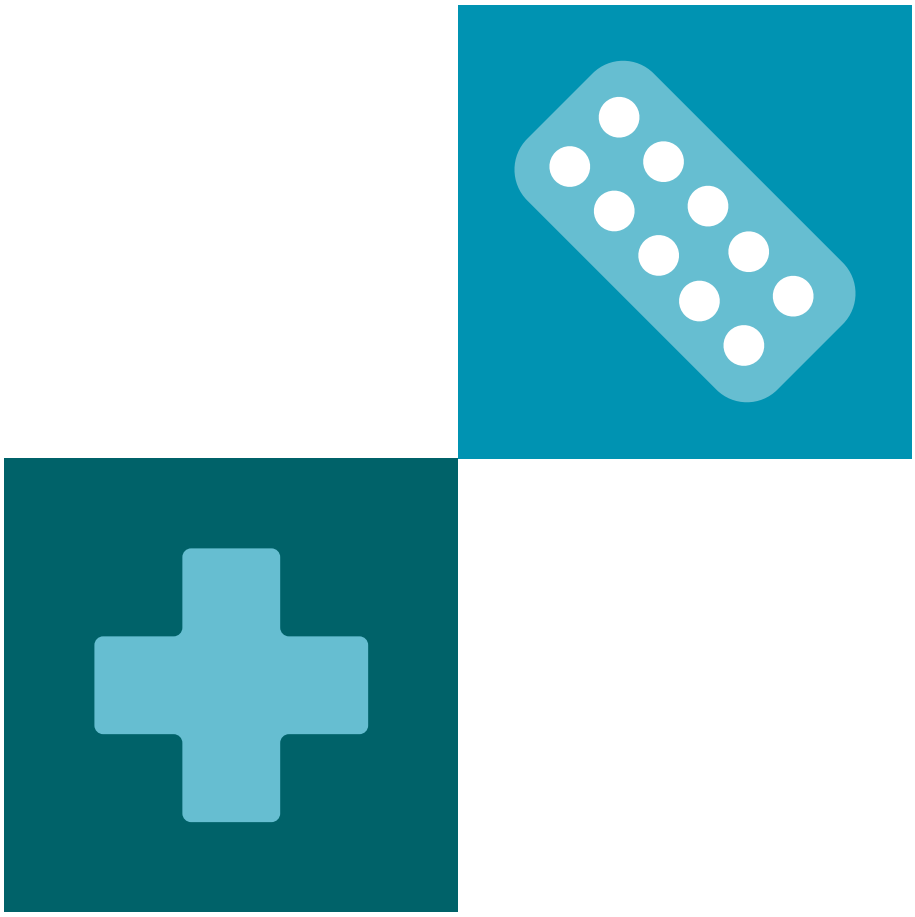
Methodology:

This measure is calculated using Medicare claims data in the Department of Health, Disability and Ageing Enterprise Data Warehouse (EDW). The bulk-billing rate is defined as bulk billed services divided by total services.

Numerator: Number of General Practice Non-Referred attendance services bulk billed.

A standard script is run on Medicare claims data in the EDW to calculate the number of General Practice Non-Referred services that are bulk billed. Bulk billed services are

accurately identified as they use a distinct claiming channel that is flagged by Services Australia in the claims data. **Denominator:** Total Number of General Practice Non-Referred attendance services billed. A standard script is run on Medicare claims data in the EDW to calculate the total number of General Practice Non-Referred services. Divide the Number of General Practice Non-Referred attendance services bulk billed (numerator) by Total Number of General Practice Non-Referred Attendance services (denominator) and multiply by 100 to calculate the bulk-billing rate for General Practice Non-Referred attendances.
Measure owner: Medicare Benefits and Digital Health Division
Changes since 2026–27 Portfolio Budget Statements: Added targeted value for 2026–27. Updated program description to strengthen alignment and how it contributes to delivering Outcome 2.



Program 2.2: Hearing Services

This program contributes to Outcome 2 through access to cost-effective and affordable hearing services.

Key Activity 2.2A:

Administer the Hearing Services Program.

Performance Measure 2.2A:

a. Number of active clients receiving at least one hearing service under the Voucher Scheme during the reporting period.

b. Number of active clients receiving at least one hearing service under Community Service Obligations arrangements during the reporting period.

Targets

2026–27	2027–28	2028–29	2029–30
a. >808,000 b. 71,000	a. >824,000 b. 72,000	a. >834,000 b. 73,000	a. >829,000 b. 73,000

Assessment Scale for the 2026–27 target:

Achieved:

a. a. >808,000

b. b. 71,000

Substantially achieved:

a. 766,000 to 807,999

b. 63,900 to 70,999

Not achieved:

a. <766,000

b. ≤63,899

Measure type:

Quantitative/Output

Target Rationale:

The targets for a. and b. are based on the figures in the Hearing Australia Corporate Plan 2025–26.[21]

[21] Available at: **www.hearing.com.au/about-hearing-australia/corporate-publications/**

a. Targets are informed by historical utilisation trends and projected demand among eligible populations. The Voucher Scheme is demand driven and targets are intended to support transparency and accountability rather than constrain access to services. Thresholds allow for normal variation in service uptake and administrative timing effects while avoiding incentives that could distort service delivery.

b. Community Service Obligations (CSO) targets are based on anticipated demand within eligible cohorts, historical service utilisation and the capped funding model under which services are delivered by Hearing Australia. Targets reflect expected scale of service delivery rather than individual outcomes or service intensity.

Data Source:

Administrative data captured through routine program delivery:

- Hearing Services Online (HSO) Portal and departmental data warehouse for Voucher Scheme services
- Hearing Australia client and service records for CSO services

These systems record service delivery at the client level and support reliable, verifiable and repeatable reporting over time.

Methodology:

Performance is calculated by counting unique clients who receive at least one hearing service during the reporting period under each program component. Established business rules prevent double counting, including the exclusion of Voucher eligible clients from CSO datasets prior to aggregation.

Results are derived from complete population administrative data rather than samples or estimates.

Voucher Scheme providers must submit claims for delivery of program services within the timeframe outlined in the service provider contract. Therefore, services provided in the relevant year may not appear until after the reporting period timeframe. Audit activities may identify invalid claims that result in potential adjustments to performance figures.

Measure owner:

Chronic Conditions and Screening Division

Changes since 2026–27 Portfolio Budget Statements:

Inclusion of targets for the Hearing Services Program. Updated program description to strengthen alignment and how it contributes to delivering Outcome 2.

Program 2.3: Pharmaceutical Benefits

This program contributes to Outcome 2 through access to cost-effective and affordable medicines by guaranteeing the Pharmaceutical Benefits Scheme.

Key Activity 2.3A:

Ensure timely listing of prescription medicines on the Pharmaceutical Benefits Scheme.

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.

Targets			
2026–27	2027–28	2028–29	2029–30
≥90%	≥90%	≥90%	≥90%

Assessment Scale for the 2026–27 target:

Achieved: ≥90%

Substantially achieved: 85% to <90%

Not achieved: <85%

Measure type:

Quantitative/Output (Proxy for Effectiveness)

Target Rationale:

A 6-month timeframe reflects the time required to complete pricing negotiations, government approvals and implementation activities following sponsor acceptance in principle of a positive PBAC recommendation.

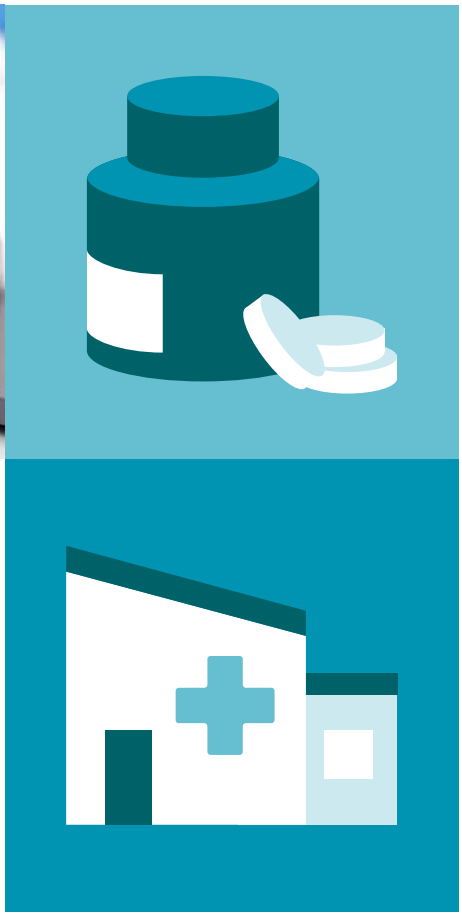
The target is based on historical performance and reflects the department's ongoing focus on ensuring timely access to new medicines while balancing value for money and sustainability of the Pharmaceutical Benefits Scheme (PBS).

Data Source:

Internal PBS tracking data, supported by publicly available information including the PBS Schedule[22] and Medicine Status[23] website.

[22] Available at: **www.pbs.gov.au/home**. Accessed, July 2026.
[23] Available at: **www.pbs.gov.au/medicinestatus/home**. Accessed, July 2026.

Methodology: The measure is calculated by determining the proportion of new medicines listed on the PBS within 6 months of in-principle agreement to listing arrangements.
Measure owner: Technology, Assessment and Access Division
Changes since 2026–27 Portfolio Budget Statements: Updated program description to strengthen alignment and how it contributes to delivering Outcome 2.



Key Activity 2.3B:

Provide affordable access to subsidised prescription medicines on the Pharmaceutical Benefits Scheme (PBS).

Performance Measure 2.3B:

Average amount patients pay for subsidised PBS prescriptions.

Targets			
2026–27	2027–28	2028–29	2029–30
$7.50 or less	$7.50 or less	$7.50 or less	$7.50 or less

Assessment Scale for the 2026–27 target:

Achieved: $7.50 or less

Substantially achieved: >$7.50 to $8.50

Not achieved: >$8.50

Measure type:

Quantitative/Output

Target Rationale:

The $7.50 target for this performance measure was chosen as it represents a challenging but achievable goal considering the trend movement in historical data related to this Key Performance Indicator and the ongoing effect of underlying policy drivers detailed below. The target has been kept constant over the 4-year measurement period to demonstrate the ongoing real reduction in patient contributions that are expected to occur as policy measures mature.

Over the past decade Australians have had a similar total number of subsidised PBS prescription medicines dispensed each year. In recent years, patient contribution costs for prescription medicines have decreased and government spending on medicines has increased.

In 2024–25, over 225.6 million subsidised PBS prescriptions were dispensed, with an aggregate patient contribution amount of $1,715.5 million. Dividing these figures gives an average patient contribution of $7.60 for each prescription. In 2024–25, the aggregate government contribution toward these medicines was $18,951.9 million, or $84.01 for each prescription.

The staged introduction of 60-day medicines[24] has reduced patient contributions costs.

[24] 60-day prescriptions have been introduced gradually in 3 stages over 12 months. The first stage was introduced on 1 September 2023. The second stage started from 1 March 2024 and the third stage from 1 September 2024.

Other initiatives, such as the lowering of the Safety Net threshold[25] and the PBS co-payment reductions and freeze measures[26] are further examples of measures that are supporting more affordable prescription medicines.
Data Source: Aggregate PBS subsidised prescriptions and patient contribution (excluding Prescriber Bag) data are taken from Table 3(b) of the Department's annual PBS Expenditure and Prescriptions Report[27], which is published by December each year.
Methodology: The average amount patients pay for subsidised PBS prescriptions is calculated by dividing aggregate patient contributions toward subsidised medications by the total number of PBS subsidised prescriptions in a given financial year. These values are sourced from Table 3(b) of the department's annual PBS Expenditure and Prescriptions Report's[28] detailed tables.
Measure owner: Technology, Assessment and Access Division
Changes since 2026–27 Portfolio Budget Statements: Revision to performance measure wording. Updated program description to strengthen alignment and how it contributes to delivering Outcome 2.

[25] 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.

[26] On 1 January 2026 the government reduced the most a patient needs to pay for a medicine listed on the PBS from $31.60 to $25. 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 your PBS medicines is the same rate as it was in 2024 and will not increase with indexation in 2025.

[27] Available at: **www.pbs.gov.au/info/statistics/expenditure-prescriptions/pbs-expenditure-and-prescriptions**

[28] Available at: **www.pbs.gov.au/info/statistics/expenditure-prescriptions/pbs-expenditure-and-prescriptions**

Program 2.4: Private Health Insurance

This program contributes to Outcome 2 through improved choice in health care services and supporting private health insurance.

Key Activity 2.4A:

Assessment of private health insurer premium applications against the public interest.

Performance Measure 2.4A:

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

Targets			
2026–27	2027–28	2028–29	2029–30
100%	100%	100%	100%

Assessment Scale for the 2026–27 target:

Achieved: 100%

Substantially achieved: N/A

Not achieved: <100%

Measure type:

Quantitative/Output

Target Rationale:

A 100% target result demonstrates the department's capacity to undertake a 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 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 Private Health Insurance (PHI) Rebate, and reinforce consumer confidence in value-for money PHI products. Close consultation with private health insurers, Australian Prudential Regulation Authority (APRA), and the Minister is required to meet the target.

Data Source:

Internal – number of compliant applications received from insurers and assessed by the department within approved timeframes.

Methodology:

The number of compliant applications assessed within approved timeframes divided by the total 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 application
- 'approved timeframe' refers to at least 60 days prior to changes taking effect from 1 April of each year, with an additional 2 weeks for the Minister to consider the submission
- A 'compliant application' is in the approved form that is received within timeframes published on the department's website and where any material errors or omissions identified by either the department or APRA have been rectified by the insurer within a deadline set by the department.

Measure owner:

Portfolio Strategy Division

Changes since 2026–27 Portfolio Budget Statements:

Updated program description to strengthen alignment and how it contributes to delivering Outcome 2. Minor edits made for clarification of performance measure calculation.

Key Activity 2.4B:

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

Performance Measure 2.4B:

The percentage of PHI clinical category and procedure type classifications[29] which are implemented concurrently with associated MBS item changes.[30]

Targets			
2026–27	2027–28	2028–29	2029–30
100%	100%	100%	100%

Assessment Scale for the 2026–27 target:

Achieved: 100%

Substantially achieved: N/A

Not achieved: <100%

Measure type:

Quantitative/Output

Target Rationale:

Targets less than 100% will lead to the health sector's inability to determine the appropriate private health insurance benefits. This will result in inaccurate benefits for Australians holding private health insurance and may result in the loss of service continuity.

Data Source:

The MBS Online XML file[31] and the Private Health Insurance clinical classifications documentation.

Methodology:

Measurement of target achievement will be determined by reconciliation processes between the MBS Online XML file and the Private Health Insurance clinical classifications documentation. Information on changes to the MBS is collated and assessed throughout the year. This information is then used to generate draft sub-ordinate legislation to enact changes and to update the MBS Online XML.

[29] Further information on clinical categories for private health insurance hospital product tier arrangements can be found at: **Private health insurance clinical category and procedure type | Australian Government Department of Health, Disability and Ageing**

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

[31] The XML file can be found at: **MBS Online - Downloads**

Prior to sub-ordinate legislation commencement, a draft MBS Online XML is generated to compare with a draft Private Health Insurance summary of changes document. Discrepancies between these documents are resolved between policy teams and the finalised MBS Online XML file and Private Health Insurance clinical classifications documentation are published. Concurrently, the sub-ordinate legislation required to enact the private health insurance changes is developed and registered.
Measure owner: Portfolio Strategy Division
Changes since 2026–27 Portfolio Budget Statements: Updated program description to strengthen alignment and how it contributes to delivering Outcome 2.

Program 2.5: Dental Services

This program contributes to Outcome 2 through access to cost-effective and affordable dental services through the Child Dental Benefits Schedule.

Key Activity 2.5A:

Continuing to work with Services Australia to monitor and increase uptake of the Child Dental Benefits Schedule program to support eligible children to access essential dental health services.

Performance Measure 2.5A:

The percentage of notified eligible children[32] accessing essential dental health services through the Child Dental Benefits Schedule in the calendar year.

Targets			
2026	**2027**	**2028**	**2029**
38% to 40%	40% to 41%	41% to 42%	42% to 43%

Assessment Scale for the 2026–27 target:

Achieved: 38% to 40%

Substantially achieved: 37% to 37.9%

Not achieved: <37%

Measure type:

Quantitative/Output (Proxy for Effectiveness)

Target Rationale:

The targets report a range based on rolling three-year average of actual performance. As a demand-driven program, Child Dental Benefits Schedule (CDBS) utilisation depends on when eligible children access dental services within a two-year capped calendar year.

This means a fixed target is not reasonably practicable; performance is therefore assessed against a target range based on actual performance from the previous three years. Achievement of this target demonstrates an increase in uptake of the program and eligible children accessing essential dental health services to support oral health.

Data Source:

2026 calendar year CDBS utilisation data is sourced from Services Australia.

[32] Children are eligible for the Child Dental Benefits Schedule 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/child-dental-benefits-schedule**

Methodology:

The following method is applied to calculate utilisation of the CDBS

CDBS utilisation (%) = $\frac{\text{Patients}^{33} \text{ (date of service – calendar year)}}{\text{Notified eligible children (calendar year)}}$

Utilisation is calculated using claims data, services with claims submitted in the following calendar year are not included in utilisation result.

Measure owner:

Primary Care Division

Changes since 2026–27 Portfolio Budget Statements:

Updated utilisation targets to reflect a target range for the performance measure. Updated program description to strengthen alignment and how it contributes to delivering Outcome 2.

[33] Patients mean CDBS eligible children who have at least one CDBS claim having a date of service in the relevant calendar year.

Program 2.6: Health Benefit Compliance

This program supports the integrity of health benefit claims for programs within Outcome 2.

Key Activity 2.6A:

Identify incorrect claiming and investigate for non-compliance.

Performance Measure 2.6A:

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

Targets			
2026–27	2027–28	2028–29	2029–30
≥80%	≥80%	≥82%	≥82%

Assessment Scale for the 2026–27 target:

Achieved: ≥80%

Substantially achieved: 78% to <80%

Not achieved: 76% to <78%

Measure type:

Qualitative/Output (Proxy for Effectiveness)

Target Rationale:

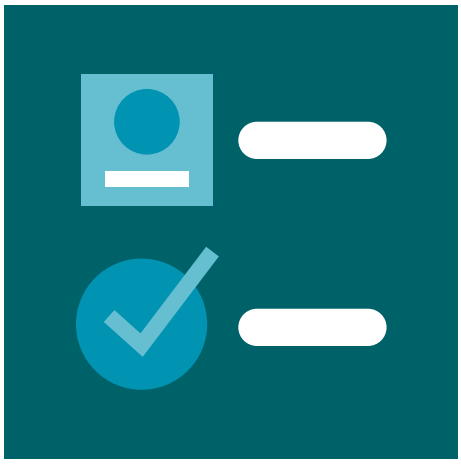
The effectiveness of the department's compliance program is critical to supporting health payment program integrity and ensuring government investment goes to intended policy outcomes. The target of ≥80% indicates that the mechanisms for identifying potentially incorrect claiming data are effective.

This measure quantifies the percentage of completed audits, practitioner reviews and investigation activities that the department correctly identifies and treats. It is intended to demonstrate:

- effective detection and analytical capability, and
- decisions to invest resources into more complex and time-consuming compliance activities are evidence-based and reflect the seriousness and scale of the identified behaviour.

Identifying non-compliant practices is one way the department assesses the effectiveness of its work to uphold the integrity of the healthcare system and implement behaviour changes by practitioners – through ensuring benefits are being paid as intended to support the government's intention to deliver a financially sustainable healthcare system for all Australians.

The division is undergoing an operating model transformation in 2026–27. This will allow for better up-front controls, data collection and subsequently, improved reporting measures.
Data Source: The data source for this measure is administrative data in the form of completed case records maintained in the Compliance Work Management System (CWMS), which is used to report against this performance measure. The specific case types that are used to report against this measure are audits, practitioner reviews and investigations. Casework data is entered into CWMS over the lifecycle of a compliance intervention as compliance officers record their observations and findings about individual compliance cases.
Methodology: Performance reporting is automatically generated from CWMS based on documented business rules. The numbers of completed and non-compliant cases reported are then validated by reviewing the CWMS Operations Listing Cases Completed Report. 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**).
Measure owner: Benefits Integrity Division
Changes since 2026–27 Portfolio Budget Statements: Updated program description to strengthen alignment and how it contributes to delivering Outcome 2.



Program 2.7: Assistance through Aids and Appliances

This program contributes to Outcome 2 by supporting targeted assistance strategies through the National Diabetes Services Scheme.

Key Activity 2.7A:

Provide targeted assistance for aids and appliances to support Australians to manage diabetes.

Performance Measure 2.7A:

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

Targets			
2026–27	2027–28	2028–29	2029–30
>765,000	>780,000	>795,000	>810,000

Assessment Scale for the 2026–27 target:

Achieved: >765,000

Substantially achieved: 740,000 to 765,000

Not achieved: <740,000

Measure type:

Quantitative/Output

Target Rationale:

The department seeks to strengthen the quality, availability, and affordability of diabetes products to ensure that people with diabetes have timely and reliable access to the supplies they need to manage their condition.

There are approximately 1.7 million people registered with the scheme including approximately 1.5 million living with diabetes and approximately 200,000 with gestational diabetes as of 12 June 2026, with about half of these people accessing subsidised products. While not all people with diabetes require access to subsidised products to manage their condition, it is important that people who do require these products have a safe, reliable and affordable path to access.

This target reflects that approximately 765,000 per year require access to diabetes products and that this number will grow over time as the number of people with diabetes increases.

Data Source:

Diabetes Australia administers the National Diabetes Services Scheme (NDSS) IT systems under a grant agreement. The current contract is in operation until 30 June 2028.

The NDSS IT systems, which are owned by the Commonwealth but administered by Diabetes Australia, hold information on people registered with the scheme including the products that they access through the scheme. This information is used to identify the number of people accessing products each year.

Methodology:

The department requests this data from Diabetes Australia under its grant agreement.

The department then validates the reported figure via direct access to the NDSS IT Systems.

Measure owner:

Technology, Assessment and Access Division

Changes since 2026–27 Portfolio Budget Statements:

Updated program description to strengthen alignment and how it contributes to delivering Outcome 2.

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

Program 3.1: Access and Information

This program contributes to Outcome 3 by supporting access and assessments through My Aged Care and navigation supports.

Key Activity 3.1A:

Facilitate access to aged care services through My Aged Care and navigation services.

Performance Measure 3.1A:

The proportion of older people and their support networks that are satisfied with their access to information through My Aged Care.

Targets			
2026–27	**2027–28**	**2028–29**	**2029–30**
a. The percentage of surveyed users who are satisfied with the service provided by the My Aged Care website: ≥65%. b. The percentage of surveyed users who are satisfied with the service provided by the My Aged Care Contact Centre: ≥95%.	a. The percentage of surveyed users who are satisfied with the service provided by the My Aged Care website: ≥65%. b. The percentage of surveyed users who are satisfied with the service provided by the My Aged Care Contact Centre: ≥95%.	a. The percentage of surveyed users who are satisfied with the service provided by the My Aged Care website: ≥65%. b. The percentage of surveyed users who are satisfied with the service provided by the My Aged Care Contact Centre: ≥95%.	a. 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%.

Assessment Scale for the 2026–27 target:

Achieved:

a. ≥65%

b. ≥95%

Substantially achieved:

a. 60% to 64.9%

b. 90% to 94.9%

Not achieved:

a. <60%

b. <90%

Measure type:

Quantitative/Effectiveness

Target 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.

My Aged Care 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.

My Aged Care Contact Centre: The planned performance target is set at ≥95% as part of a range of measures aimed at meeting high customer satisfaction expectations. The target has been reviewed and reflects a balance between the desire to enhance customer satisfaction and the need for a practicable and effective target. The target represents a very high level of service delivery and demonstrates high customer satisfaction with the Contact Centre.

Ongoing reforms may impact the number and complexity of interactions with the My Aged Care website and Contact Centre which may affect customer satisfaction levels.

The substantially achieved targets have been set to demonstrate that the satisfaction levels were within 5% of the achieved ratings.

Data Source:

a. My Aged Care website:

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

b. My Aged Care Contact Centre:

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

The data is not publicly available due to privacy reasons and commercial confidentiality arrangements.

Methodology:

a. My Aged Care website:

The data used to report against this performance measure is the percentage of satisfied users of My Aged Care website services - noting that ‘users’ refers to ‘visitors’ to the My Aged Care website.

‘Satisfied’ visitors to the website are calculated from an aggregate of user responses to 4 questions within the survey that measure key indicators of website satisfaction.

The 4 survey questions are designed to measure satisfaction with 5 key indicators, namely: usability; clarity; helpfulness; intent; and overall satisfaction.

The satisfaction percentage is determined by aggregating the responses to the survey questions.

Specifically, this involves converting the responses to the 5-point rating scale ('Strongly disagree', 'disagree', 'neither agree nor disagree', 'agree', 'strongly agree') to be either satisfied, neutral or dissatisfied. The frequency and percentages for each type of response are then divided by the number of responses to that question. The total number of 'satisfied' responses are divided by the total number of responses to produce a 'satisfied' percentage score and that is the reported result.

The survey data is verified independently and by the department to ensure its reliability, completeness and accuracy.

b. My Aged Care Contact Centre:

The data used to report against this performance measure is a survey of user satisfaction of the My Aged Care Contact Centre. Users call the My Aged Care Contact Centre and are given the opportunity to opt out of being surveyed through a response to a telephone prompt.

A random sample of users is taken to support user satisfaction, and the minimum sample size is 1% of projected calls to the Consumer Line and the Industry Line. For consumers, surveys are conducted within 24 to 48 hours of the caller interaction with the Contact Centre. For the Industry Line, callers are transferred from the Contact Centre to a specified telephone number.

'Satisfied' callers to the My Aged Care Contact Centre are those who give the Contact Centre a score of 6–10 on a scale of 0–10 in response to the My Aged Care Customer Satisfaction Survey question: 'How satisfied were you overall with your experience?'.

The percentage of satisfied users is calculated by taking the number of responses with a score of 6–10 and dividing it by the total number of responses then multiplying it by 100.

The survey is conducted and verified for reliability and accuracy through an independent third-party market research company.

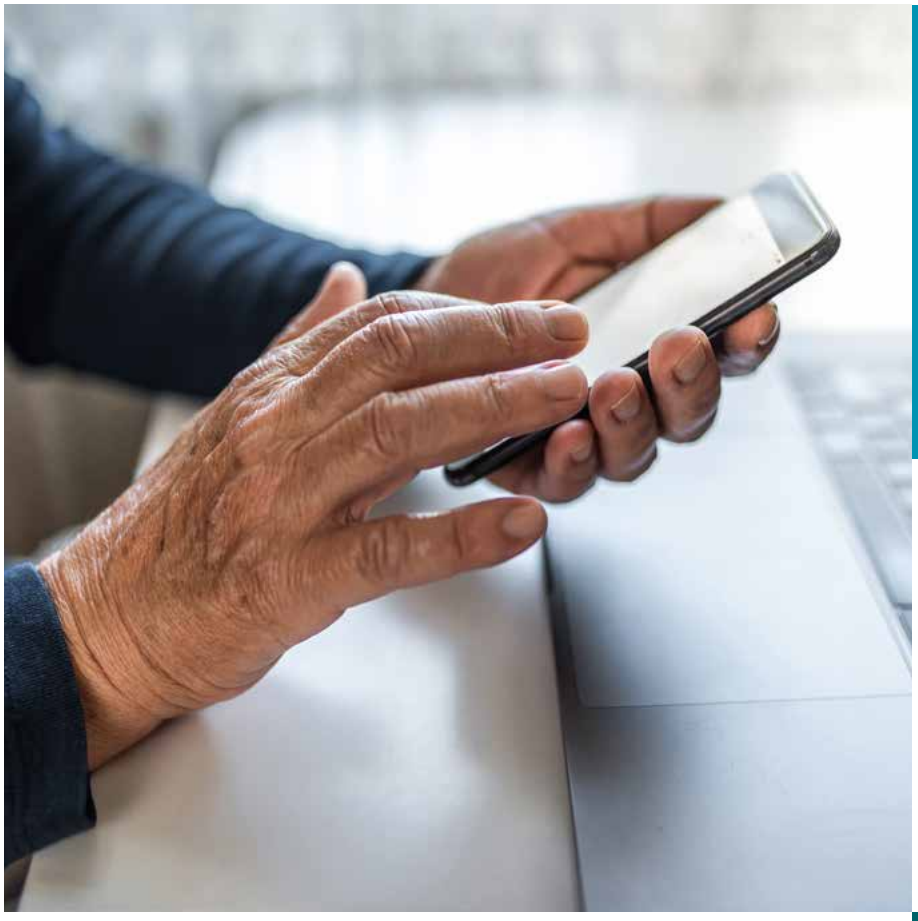
Note: A new survey provider has been selected, and a review of the satisfaction survey methodology and questions is underway to ensure their relevance. Any changes will be implemented from 1 July 2026. The core questions supporting the calculation of the Contact Centre satisfaction score are not expected to change.

Measure owner:

Access and Home Support Division

Changes since 2026–27 Portfolio Budget Statements:

Updated program description to strengthen alignment and how it contributes to delivering Outcome 3. Revision made to the Performance Measure. The Performance Measure remains equivalent to the 2025–26 Performance Measure. The target b. has been updated to ≥95% to align with the contracted Key Performance Indicator for Client Satisfaction with the My Aged Care Contact Centre.



Key Activity 3.1B: Facilitate access to aged care services through undertaking eligibility/need assessments.			
Performance Measure 3.1B: The proportion of older people who are assessed for service need within allocated priority timeframes.			
Targets			
2026–27	**2027–28**	**2028–29**	**2029–30**
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. c. Comprehensive Hospital-based assessments completed within the allocated priority timeframes (≥90%):	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. c. Comprehensive Hospital-based assessments completed within the allocated priority timeframes (≥90%):	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. c. Comprehensive Hospital-based assessments completed within the allocated priority timeframes (≥90%):	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. 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.	I. High priority: 5 calendar days II. Medium priority: 10 calendar days III. Low priority: 15 calendar days.	I. High priority: 5 calendar days II. Medium priority: 10 calendar days III. Low priority: 15 calendar days.	I. High priority: 5 calendar days II. Medium priority: 10 calendar days III. Low priority: 15 calendar days.

Assessment Scale for the 2026–27 target:

Achieved:

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

Substantially achieved:

80% to 89.9% of the respective types of assessments (a. to c.) are completed within the allocated priority timeframes.

Not achieved:

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

Measure type:

Quantitative/Effectiveness

Target Rationale:

The planned performance target of ≥90% represents the proportion of assessments completed within specified priority timeframes and is established through a contractual agreement with assessment organisations. Meeting this target supports the timely delivery of assessments to clients.

External circumstances outside the control of both the department and assessment organisations (such as availability of clients and/or their representatives) can influence assessment timeframes.

Data Source:

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

The data is not publicly available due to privacy reasons and commercial confidentiality arrangements.

Methodology:

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

Measure owner:

Access and Home Support Division

Changes since 2026–27 Portfolio Budget Statements:

Updated program description to strengthen alignment and how it contributes to delivering Outcome 3. Revision made to the Key Activity and Performance Measure. The Performance Measure remains equivalent to the 2025–26 Performance Measure.

Program 3.2: Aged Care Services

This program contributes to Outcome 3 by enabling access to at home support and residential care for older people who require assistance.

Key Activity 3.2A:

Enable the delivery of residential care services that support older people.

Performance Measure 3.2A:

Older people receive residential care services that support their care needs.

Targets			
2026–27	**2027–28**	**2028–29**	**2029–30**
a. 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. b. All approved residential aged care homes have at least one RN on-site and on duty 24 hours a day, 7 days a week.	a. Maintain a sector-wide average of 215 minutes per resident per day, including 44 minutes of direct care by an RN per day. b. All approved residential aged care homes have at least one RN on-site and on duty 24 hours a day, 7 days a week.	a. Maintain a sector-wide average of 215 minutes per resident per day, including 44 minutes of direct care by an RN per day. b. All approved residential aged care homes have at least one RN on-site and on duty 24 hours a day, 7 days a week.	a. Maintain a sector-wide average of 215 minutes per resident per day, including 44 minutes of direct care by an RN per day. b. All approved residential aged care homes have at least one RN on-site and on duty 24 hours a day, 7 days a week.

Assessment Scale for the 2026–27 target:

Achieved:

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

b. All approved residential aged care homes 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.

Not achieved:

a. Sector-wide average of below 215 minutes per resident per day, including 44 minutes of direct care by an RN per day.
b. Average percentage of reported hours an RN was on-site and on duty is below 100.00%.

Measure type:

Quantitative/Output

Target Rationale:

a. In line with the recommendations of the Royal Commission into Aged Care Quality and Safety, the Government increased the care minutes target to 215 minutes per resident per day in October 2024. Mandatory care minutes ensure that older people in residential care homes receive the dedicated care time they need. The target is set consistent with Government policy and legislation.
b. The RN 24/7 measure was introduced as part of the Government's 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. The 24/7 RN requirement aims to improve the quality of care that residents living in residential care homes receive and restore confidence to older people, their families, and carers that residents will have access to the highest level of clinical nursing care to meet their individual needs at all times.

Data Source:

a. 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 the Government Provider Management System (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 Aged Care Data Warehouse (ACDW) through the extract, transform and load (ETL) process.
b. Residential aged care providers report gaps in RN coverage through the RN application on GPMS for each of their homes. The RN data is made available/synchronised in the ACDW through the ETL process.

Methodology:

a. 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, Enrolled Nurse and personal care worker 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.

b. RN 24/7

The average availability of an 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.

Measure owner:

Dementia, Diversity, and Residential Care Division

Changes since 2026–27 Portfolio Budget Statements:

Updated program description to strengthen alignment and how it contributes to delivering Outcome 3. Performance Measure 3.2A, previously reported as Performance Measure 3.2B in the 2025–26 reporting period, has been revised following the transfer of component 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*) to Program 3.3 in 2026–27. The Performance Measure and Key Activity for 3.2A has been updated to reflect this change.

Key Activity 3.2B:			
Enable the delivery of residential care and home care services that support older people.			
Performance Measure 3.2B: 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.			
Targets			
2026–27	**2027–28**	**2028–29**	**2029–30**
a. i. Older people aged 50 to 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	a. i. Older people aged 50 to 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	a. i. Older people aged 50 to 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	a. i. Older people aged 50 to 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%	with their representation in Australian population estimates: Target 10.6%	with their representation in Australian population estimates: Target 10.6%	with their representation in Australian population estimates: Target 10.6%
Assessment Scale for the 2026–27 target: **Achieved:** a. i. ≥2.7% ii. ≥1.3% b. ≥10.6% **Substantially achieved:** a. i. >2.2% to <2.7% ii. >1.0% to <1.3% b. >8.5% to <10.6% **Not achieved:** a. i. ≤2.2% ii. ≤1.0% b. ≤8.5%			
Measure type: Quantitative/Output			

Target Rationale:

a. The planned performance assesses the output of activities in providing quality and culturally safe care to older First Nations people with diverse backgrounds and life experiences. The target is based on the current older population estimate from the Australian Bureau of Statistics (ABS) census data.[34] The department aims to ensure older First Nations people can access the aged care services they are assessed as needing – with such services to be delivered in a manner that is culturally safe, and supports them to age with respect and dignity.

b. The planned performance assesses the output of activities providing quality, culturally appropriate and safe care to older people in locations where they live, including those in rural and remote communities. The target measures the output of how many older people living in rural and remote areas are accessing aged care services. The target 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 aged care services they are assessed as needing regardless of where they live – with quality and safe services to be delivered close to home where possible, so that older people are supported to stay close to their loved ones and communities for as long as possible.

Data Source:

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, recipient demographic information captured in the data for aged care programs transmitted to the department from Services Australia).

b. Older people accessing Australian Government funded aged care services who live in rural and remote areas, as indicated by:

   - for programs delivering care in peoples' homes, their address location as recorded in their My Aged Care personal client record or other systems (for example, recipient location information captured in the data for aged care programs transmitted to the department from Services Australia)
   - for the residential aged care program, the physical address of their provider as recorded in the Government Provider Management System (GPMS).

[34] Australian Bureau of Statistics, **Population: Census, 2021 | Australian Bureau of Statistics**, accessed July 2026.

Methodology:

Client counts are first extracted from the Department of Health, Disability and Ageing's 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 departmental systems, these being the Aged Care Gateway (ACG, being the systems behind the My Aged Care personal client record and data collected in needs assessment services) and the GPMS for attributes related to the aged care service that clients received care through. In addition, data transmitted to the department from systems held at external agencies are also incorporated in the ACDW; of relevance here are data from the 'Aged Care Management Payment System' (ACMPS) for person- and episode-level attributes relating to recipients of residential aged care and of Support at Home services, and the 'Data Exchange' (DEX) for person- and episode level attributes relating to recipients of basic support at home through the Commonwealth Home Support Program (CHSP).

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 3.2B(a)) or whose location information places them in a rural or remote area (for 3.2B(b)), by all clients of those programs. Note that any clients for whom First Nations identity are not known or is missing (for 3.2B(a)) or for whom location data are invalid or missing (for 3.2B(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.

Measure owner:

Market and Stewardship Division

Changes since 2026–27 Portfolio Budget Statements:

Updated program description to strengthen alignment and how it contributes to delivering Outcome 3. This Performance Measure was reported as 3.2C in the 2025–26 reporting period. Nil changes to the performance information.

Key Activity 3.2C:

Enable the delivery of home care services that support older people.

Performance Measure 3.2C:

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.[35]

Targets			
2026–27	**2027–28**	**2028–29**	**2029–30**
a. 420,000 b. 860,000	a. 420,000 b. 860,000	a. 420,000 b. 860,000	a. 420,000 b. 860,000

Assessment Scale for the 2026–27 target:

Achieved:

a. 420,000

b. 860,000

Substantially achieved:

a. 405,000 to 419,999

b. 850,000 to 859,999

Not achieved:

a. ≤404,999

b. ≤849,999

Measure type:

Quantitative/Output

Target 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 420,000 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 of an average wait time of

[35] A new measure and target for performance measure b. will be developed following its transition to the Support at Home program (which will occur no earlier than 1 July 2027).

3 months to receive care by November 2027. 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 2025–26 performance target. This target refers to the anticipated participants receiving services under the Commonwealth Home Support Program (CHSP). The CHSP funding is 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 Grant Payment System funding data indicates that average client use being $3,500 to $3,750 per annum per client.

Data Source:

a. Place allocation data from the My Aged Care Gateway (Siebel system) will be extracted by the Department of Health, Disability and Ageing's Aged Care Data Warehouse (ACDW) and analysed. Services Australia provides the main data source for billing and administrative data and is stored in the ACDW.
b. Department of Social Services' Data Exchange is where provider service delivery is reported. Data is transferred to the department's ACDW.

Methodology:

a. Data is extracted from the ACDW and transformed based on business rules to meet reporting requirements. Analysis will then identify the number of participants that are assigned or committed to Support at Home places in the financial year of interest.
b. The calculation methodology is the number of clients that had one or more CHSP sessions for a CHSP service in the given financial year.

Measure owner:

Access and Home Support Division

Changes since 2026–27 Portfolio Budget Statements:

Updated program description to strengthen alignment and how it contributes to delivering Outcome 3. Revision made to the Key Activity. This Performance Measure was reported as 3.2D in the 2025–26 reporting period.

Program 3.3: Aged Care Quality

This program contributes to Outcome 3 by supporting the delivery of high-quality aged care services that meet the needs and expectations of older people.

Key Activity 3.3A:

Monitor and support aged care services to provide high-quality care experiences for older people.

Performance Measure 3.3A:

The extent to which older people in residential aged care report receiving high-quality care.

Targets			
2026–27	**2027–28**	**2028–29**	**2029–30**
a. Maintain or increase the average Residents' Experience Survey (RES) Score (%) of approved residential care homes (ARCHs) from the previous year's result. b. Maintain or increase percentage of residents (or proxies on behalf of a resident) who completed the Quality of Life–Aged Care Consumers (QOL-ACC) and who report 'good' or 'excellent' quality of life in comparison to the 2025–26 results.	a. Maintain or increase the average RES Score (%) of ARCHs from the previous year's result. b. Maintain or increase percentage of residents (or proxies on behalf of a resident) who completed the QOL-ACC and who report 'good' or 'excellent' quality of life in comparison to the 2026–27 results.	a. Maintain or increase the average RES Score (%) of ARCHs from the previous year's result. b. Maintain or increase percentage of residents (or proxies on behalf of a resident) who completed the QOL-ACC and who report 'good' or 'excellent' quality of life in comparison to the 2027–28 results.	a. Maintain or increase the average RES Score (%) of ARCHs from the previous year's result. b. Maintain or increase percentage of residents (or proxies on behalf of a resident) who completed the QOL-ACC and who report 'good' or 'excellent' quality of life in comparison to the 2028–29 results.

Assessment Scale for the 2026–27 target:

Achieved:

a. Maintain or increase on previous year's result.

b. Maintain or increase on previous year's result.

Substantially achieved:

a. N/A.

b. N/A.

Not achieved:

a. Decrease on previous year's result.

b. Decrease on previous year's result.

Measure type:

Quantitative/Effectiveness

Target Rationale:

a. The planned performance for 2026–27 aims to achieve an improvement in provider behaviour in response to the department's reform activities since 2022. The target measures older peoples' experiences of residential aged care homes, including their perspectives on whether they are being provided with high-quality care. Success will be measured by maintaining or improving the average residents' experience survey score, as the sector matures in line with aged care reforms, resulting in the delivery of high-quality care.

b. The QOL-ACC survey measures the quality of life of a resident in residential aged care. By establishing a baseline of the percentage of residents (or proxies on behalf of a resident) 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 residents (or proxies on behalf of a resident) who complete a QOL-ACC survey and report 'good' or 'excellent' quality of life will increase or be maintained.

Data Source:

a. The performance measure is calculated using quantitative survey data collected annually through 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.

   The performance measure is calculated using individualised resident scores for each home and number of residents who participated at the home. Individual resident scores are not publicly available due to privacy requirements.

   Results relating to RES are published at an aggregated level. These results are published for Star Ratings on My Aged Care and in the Star Ratings quarterly data extracts (excel)

which are on the department's website. This details the percentage of residents who responded against the four-point scale ('always', 'most of the time', 'some of the time', and 'never'). RES results are also de-identified and combined into a Residents' Experience Report which is provided to aged care providers. RES data is also analysed at the sector level and key findings released in report form on the department's website.

b. Data is collected by residential aged care homes and reported in the Government Provider Management System (GPMS) Registered Provider Portal. The data in GPMS is available for providers to view and is also stored in the Aged Care Data Warehouse (ACDW). Any changes or updates made to the data in GPMS are subsequently updated in the ACDW daily. The data is available to the department via Qlik dashboards, GPMS and ACDW internal reports.

   Results from the QOL-ACC survey of the percentage of residents (or proxies on behalf of a resident) who complete a QOL-ACC survey and report 'good' or 'excellent' are published by the Australian Institute of Health and Welfare (AIHW) on the GEN Aged Care Data website quarterly.

Methodology:

a. The performance 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: '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 3.3A.

   To calculate the ARCH-level Average Score (%):

   1. The ARCH Total Score is calculated by summing the individual resident scores per residential care home.
   2. The ARCH Total Score is divided by the number of residents that participated in RES at the service to return the ARCH Average Score.
   3. The sum of all ARCH Average Scores is divided by the number of participating residential care homes to return the ARCH-level average RES Score.
   4. To obtain the ARCH-level average RES Score as a percentage, the value is divided by 48 (maximum total score of RES) and multiplied by 100.

b. Quality of Life–Aged Care Consumers survey:

   The department receives National Aged Care Quality Indicator program data submitted at an aggregate level for each residential aged care home. A copy of the data is provided to the AIHW quarterly to analyse and publish on the GEN Aged Care Data website, based on remoteness category, national, state and territory levels. The performance measure is calculated based on the percentage of residents (or their proxies) who complete the QOL-

ACC survey, who report ‘good’ or ‘excellent’ quality of life through self-completion, interviewer facilitated completion or proxy-completion.
Measure owner: Quality and Assurance Division
Changes since 2026–27 Portfolio Budget Statements: Updated program description to strengthen alignment and how it contributes to delivering Outcome 3. Program 3.3 and Performance Measure 3.3A have been revised to better reflect the department’s role in supporting and overseeing the delivery of high-quality aged care services. Performance Measures 3.2A and 3.2B(a), previously reported under Program 3.2 in 2025–26, have been consolidated and transferred to Program 3.3 to form Performance Measure 3.3A. The associated targets and data sources have been retained and transferred from the 2025–26 Performance Measures 3.2A and 3.2B(a). The program description, Key Activity and Performance Measure have been updated to reflect this consolidation.

Outcome 4

Disability and Carers

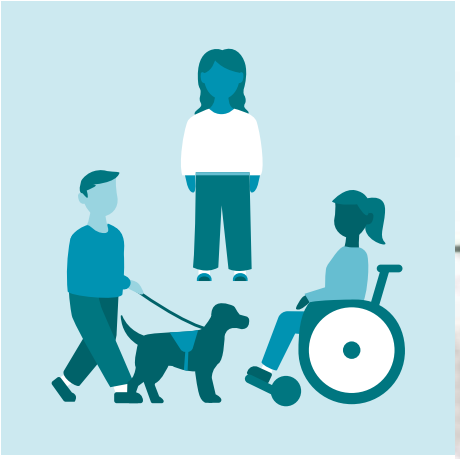
Outcome 4: Disability and Carers

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: Disability and Carers

This program contributes to Outcome 4 by supporting people with disabilities and carers to actively participate in community and economic life.

Key Activity 4.1A: Support and monitor Carer Gateway service providers to deliver services that improve carers' wellbeing.			
Performance Measure 4.1A: Extent to which the wellbeing of carers who are registered with Carer Gateway local service providers is assessed as improved.			
Targets			
2026–27	**2027–28**	**2028–29**	**2029–30**
a. Percentage (at least 30%) of carers registered with Carer Gateway local service providers assessed as having improved carer wellbeing in the current reporting period. b. Percentage (at least 35%) of carers registered with Carer Gateway local service providers assessed as having improved carer wellbeing since the program commenced.	a. Percentage (at least 30%) of carers registered with Carer Gateway local service providers assessed as having improved carer wellbeing in the current reporting period. b. Percentage (at least 35%) of carers registered with Carer Gateway local service providers assessed as having improved carer wellbeing since the program commenced.	a. Percentage (at least 30%) of carers registered with Carer Gateway local service providers assessed as having improved carer wellbeing in the current reporting period. b. Percentage (at least 35%) of carers registered with Carer Gateway local service providers assessed as having improved carer wellbeing since the program commenced.	a. Percentage (at least 30%) of carers registered with Carer Gateway local service providers assessed as having improved carer wellbeing in the current reporting period. b. Percentage (at least 35%) of carers registered with Carer Gateway local service providers assessed as having improved carer wellbeing since the program commenced.

Assessment Scale for the 2026–27 target:

Achieved:
a. ≥30%
b. ≥35%
Substantially achieved:
a. N/A
b. N/A
Not achieved:
a. <30%
b. <35%

Measure type:

Quantitative/Effectiveness

Target Rationale:

Measuring the extent to which the wellbeing of carers registered with Carer Gateway local service providers is assessed as improved demonstrates the effectiveness of support delivered under the Integrated Carer Support Service program in contributing to one of the long-term outcomes: improved carer wellbeing.

The measure focuses on the proportion of registered carers whose wellbeing is assessed as improved, providing an indicator of program effectiveness in delivering outcomes for carers.

This is an ongoing measure with 2 targets:

- Annual target: measuring the proportion of carers within the reporting period whose wellbeing is assessed as improved.
- Long-term target: the proportion of all registered carers since program commencement whose wellbeing is assessed as improved. This target recognises that improved carer wellbeing is a longer-term outcome that requires ongoing effort to achieve. Monitoring this measure annually provides insight into trends in wellbeing outcomes and reflects expectations of increasing levels of carer wellbeing as the program matures and carer uptake increases.

Together, these targets align with annual reporting timeframes by enabling reporting on outcomes for each financial year, while also demonstrating long-term assessment of carer wellbeing.

Outcomes for carers who enter the program with a high level of wellbeing and maintain a high level of wellbeing are not captured by this measure, as the measure includes improvement in wellbeing scores over time but not maintenance. The scale used to measure wellbeing has a maximum score of 5, so it is not able to record improvement for carers who enter the program with a wellbeing score of 5. The current future year targets are informed by trends in wellbeing outcomes to date. Targets will be monitored and re-assessed over time as additional trend data becomes available.

Data Source:

Carers Star™ 'needs-assessments' conducted by Carer Gateway service providers and entered into the Department of Social Services Data Exchange (DEX).

The data is not publicly available due to privacy requirements and security considerations.

Methodology:

The methodology for each of the targets is:

a. The percentage of carers assessed as having improved wellbeing within the performance reporting period is calculated using Carers StarTM 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.

b. The percentage of carers assessed as having improved wellbeing for all registered carers since the program commenced is calculated using data from Carers StarTM needs-assessments, across all reporting periods from 1 January 2020 to the end of the current reporting period.

The Carers Star™ needs-assessment is entered into the DEX as a Circumstances SCORE. Data results are produced using DEX QLIK Sense reporting of client outcomes. QLIK Sense pairs available earliest and latest SCORE data entered in DEX for each client in each DEX reporting period to identify their individual SCORE change and then produces the percentage of carers who are assessed as having improved wellbeing.

Measure owner:

Carers, Autism, Markets and Safeguards Division

Changes since 2026–27 Portfolio Budget Statements:

Updated program description to strengthen alignment and how it contributes to delivering Outcome 4. Revision made to the Key Activity and Performance Measure. The Performance Measure remains equivalent to the 2025–26 Performance Measure.

Key Activity 4.1B:

Improve outcome reporting under Australia's Disability Strategy 2021–2031 (the Strategy) to build an understanding of its effectiveness in supporting people with disability.

Performance Measure 4.1B:

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

Targets			
2026–27	**2027–28**	**2028–29**	**2029–30**
The number of measures under the Strategy's 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.

Assessment Scale for the 2026–27 target:

Achieved: Increase on previous year.

Substantially achieved: N/A.

Not achieved: Decrease or same result as previous year.

Measure type:

Quantitative/Output

Target Rationale:

Measuring the extent to which the evidence base is built for the Strategy aims to improve tracking of what is happening for people with disability over time. It builds an understanding of the effectiveness of the Strategy and enables monitoring of outcomes across 7 key areas of people's lives.

Increasing the number of measures under the Strategy's 2021–2031 Outcomes Framework relies on the department successfully leading efforts to build the evidence base for reporting progress for the Strategy. Reporting is available for 63 measures as of 30 June 2026 and is found at Australia's Disability Strategy Outcomes Framework webpages[36] (hosted by the Australian Institute of Health and Welfare (AIHW)).

[36] AIHW, **Reporting on Australia's Disability Strategy 2021-2030**, accessed July 2026.

Data Source:

The data used for this performance measure is sourced by counting the number of measures with data available on the Strategy's Outcome Framework webpages[37] as published by AIHW. As data becomes available for new Outcomes Framework measures, the webpages are updated to reflect the most recent data through quarterly updates. The measures being reported are publicly available via the Outcomes Framework webpages.

Methodology:

Determining the total number of measures reported under the Strategy's 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 measures that are reported across the Strategy's Outcomes Framework. The focus is on developing and collecting data on those measures (future measures) that are currently not being reported.

Measure owner:

Disability Strategy Supports and Inclusion Division

Changes since 2026–27 Portfolio Budget Statements:

Updated program description to strengthen alignment and how it contributes to delivering Outcome 4. Revision made to the Key Activity.

37 AIHW, **Reporting on Australia's Disability Strategy 2021-2030**, accessed July 2026.

Program 4.2: National Disability Insurance Scheme

This program contributes to Outcome 4 by supporting the wellbeing and social and economic participation of people with disability, and their families and carers, by enabling the ongoing functioning of the National Disability Insurance Scheme (NDIS).

Key Activity 4.2A:

Provide stewardship to influence the development of the market and workforce for NDIS participants.

Performance Measure 4.2A:

The extent to which the Department of Health, Disability and Ageing contributes to the effective operation and development of the NDIS market and workforce through market stewardship.

Targets
2026–27 to 2029–30
The extent to which the department's market stewardship contributes to the operation and development of the NDIS market and workforce will be assessed by examining 3 case studies: • The establishment of the NDIS Market Stewardship Framework to enable more active and coordinated management of the NDIS market and workforce. • The expansion of provider registration across the NDIS market through a risk-proportionate model to strengthen oversight and safeguard participant outcomes. • The introduction of reforms to improve quality of providers including commissioning approaches. These case studies will demonstrate, with supporting evidence, how the department's advice informed Government decision-making and implementation and contributed to changes in the development and operation of the NDIS market and workforce. The case studies will assess how these decisions have influenced the operation of the NDIS market and workforce, including implications for participants and impacts on market structure and provider behaviour.

Assessment Scale for the 2026–27 target:

Achieved:

The case study provides clear, credible evidence demonstrating that Government decision-making informed by the department's advice produced changes to the NDIS market or workforce.

Substantially achieved:

The case study provides some evidence that Government decision-making was informed by the department's advice and shows some links to changes to the NDIS market or workforce.

Not achieved:

The case study lacks sufficient documented evidence of the department's contribution to decision making or does not demonstrate an evidenced link to changes in the NDIS market or workforce.

Each case study will be assessed individually against this scale.

Measure type:

Qualitative/Effectiveness

Target Rationale:

The department provides advice to Government to support the development of a more responsive, sustainable and high-quality NDIS market and workforce.

Through its market stewardship role, the department identifies emerging risks and gaps, develops evidence-based policy advice, and supports Government decision-making that shape market and workforce settings over time.

This work operates in a complex, multi-actor environment, where outcomes are influenced by a range of factors beyond the department's direct control. As a result, it is not feasible to directly attribute system-level outcomes to departmental activity. For this reason, the performance measure adopts an evaluative, case study-based approach to assess how the department contributes to Government decision-making and how those decisions shape the development of the NDIS market and workforce.

The case studies provide a structured way to examine complex policy interventions, demonstrating how the department's advice contributes to decisions that influence the operation of the market and workforce, and their implications for participants. This approach focuses performance assessment on the quality and influence of advice, supported by documented evidence to ensure results are transparent and verifiable over time.

Data Source:

The department's Electronic Documents and Records Management System (Content Manager), supported by internal program records and documentation of market stewardship activities, policy advice and case study materials.

Methodology:

We will assess performance through 3 case studies that demonstrate the department's contribution to the development of the NDIS market and workforce for 2026–27 reporting.

The case studies are selected to reflect key areas of market stewardship and provide a balanced view of the department's work, informed by internal governance processes.

We will use an evaluative approach to examine each case study, including:

- the issue or market challenge addressed
- the analysis and advice developed
- how that advice informed Government decision-making and implementation
- how the decision has influenced the NDIS market and workforce.

We will draw on documented evidence, including policy advice, briefs and decision records, to understand how the department contributes to decisions that shape market and workforce settings for each case study. Supporting information on market stewardship activities provides context for the case studies and the department's broader contribution during the reporting period.

Measure owner:

Carers, Autism, Markets and Safeguards Division

Changes since 2026–27 Portfolio Budget Statements:

Updated program description to strengthen alignment and how it contributes to delivering Outcome 4. The Key Activity and Performance Measure has been refined to better reflect the department's role in market stewardship of the NDIS market and workforce. For 2026–27, 3 case studies will be used to demonstrate performance. This includes:

- reframing the measure to emphasise the department's role in providing evidence-based advice and supporting Government decision-making that shapes NDIS market and workforce settings
- introducing an evaluative, case study-based approach to demonstrate how the department's advice contributes to the development of the NDIS market and workforce
- reducing the emphasis on quantitative activity measures, while retaining appropriate supporting evidence to ensure transparency and continuity in performance reporting.

These changes strengthen the focus on the department's advice and the impact on the NDIS market and workforce, providing a more meaningful representation of its contribution to the development of the NDIS market and workforce.

Key Activity 4.2B:

Manage sustainable NDIS cost growth.

Performance Measure 4.2B:

NDIS cost growth is sustainable.

Targets			
2026–27	**2027–28**	**2028–29**	**2029–30**
Annual Scheme cost growth of 5 to 6% or lower.	Annual Scheme cost growth of 5 to 6% or lower.	Annual Scheme cost growth of 5 to 6% or lower.	Annual Scheme cost growth of 5 to 6% or lower.

Assessment Scale for the 2026–27 target:

Achieved: Annual Scheme cost growth is 5 to 6% or lower.

Substantially achieved: N/A.

Not achieved: Annual Scheme cost growth is above 6%.

Measure type:

Quantitative/Effectiveness

Target Rationale:

In April 2023, National Cabinet committed to an annual growth target in the total costs of the Scheme of no more than 8% by 1 July 2026, with further moderation of growth as the Scheme matures.

On 30 January 2026, National Cabinet committed to undertake necessary reforms to achieve annual cost increases of 5 to 6% or lower, as part of the Heads of Agreement on the National Health Reform Agreement, NDIS reforms and Foundational Supports.

The 2026–27 Budget introduced a range of measures to reduce Scheme growth. Legislative amendments have been introduced to make changes effective from the 2026–27 financial year. Resetting many of the NDIS design features would see NDIS costs grow at a more sustainable rate, securing the future of the NDIS.

Data Source:

Estimated actual and projected scheme costs for 2026–27 as obtained from the Department of Health, Disability and Ageing Portfolio Budget Statements (reflecting Central Budget Management System positions).

Methodology:

The department will report against estimated actual and forward estimates of scheme costs for 2026–27 and subsequent years as reported in the Department of Health, Disability and Ageing Portfolio Budget Statements. Tracking estimated actual and forward estimates of Scheme costs for 2026–27, and subsequent years, across the years will show if the NDIS reforms are delivering the expected impacts and if Scheme cost growth targets are expected to be met.

Measure owner:

NDIS Strategy and Policy Division

Changes since 2026–27 Portfolio Budget Statements:

Updated program description to strengthen alignment and how it contributes to delivering Outcome 4. Revision made to the Key Activity. The target has also been revised since the publication of the Portfolio Budget Statements 2026–27 to align with the decision of National Cabinet to further reduce scheme growth. This will be implemented through legislative amendments currently before the parliament and other reform measures announced in the Budget 2026–27.

Key Activity 4.2C:

Legislative amendments developed to support NDIS eligibility/access and participant plans, including primary and subordinate legislation and supporting documents on the instruction of Government.

Performance Measure 4.2C:

Legislative amendments and statutory rules developed for Government outlined in the NDIS Amendment (Securing the NDIS for Future Generations) Bill 2026 and NDIS Amendment (Getting the NDIS Back on Track Bill No. 1) Amendment 2024.

Targets

2026–27	2027–28	2028–29	2029–30
Legislative amendments and statutory rules developed for Government.	Statutory rules developed for Government.	Statutory rules developed for Government.	Statutory rules developed for Government.

Assessment Scale for the 2026–27 target:

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.

Measure type:

Quantitative/Output

Target Rationale:

The National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026 was introduced to Parliament on 14 May 2026 to give effect to the changes announced in the 2026–27 Budget to secure the future of the NDIS. Changes focus on:

- addressing fraud within the NDIS
- clarifying eligibility and the supports the NDIS funds
- updating governance and administrative arrangements.

New framework planning was enabled by legislative amendments under the *National Disability Insurance Scheme Amendment (Getting the NDIS Back on Track No. 1) Act 2024*, which commenced on 3 October 2024.

These reforms build on work to implement key recommendations of the Independent Review into the NDIS and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. Both the NDIS Review and the Disability Royal Commission undertook extensive engagement and consultation with the disability community. While some changes will be implemented in the short term, many will be delivered over a longer period to allow for further consultation with people with disability and their families and carers, advocates, providers and experts.

Data Source:

Data sources are:

- Drafting instructions/email(s) to the Office of Parliamentary Council.
- Disability Reform Ministerial Council (DRMC) and Disability Senior Officials Group (DSOG) papers.
- Records of stakeholder meetings (including DRMC and DSOG).
- Tabling submission pack, including Explanatory Memorandum, background/legislation briefing pack, Second Reading Speech, Q&As.

Methodology:

Milestones:

1. New or amended legislative instruments enabled by amendments to the *National Disability Insurance Scheme Act 2013*.
2. Securing agreement of states following engagement with stakeholders (state and territory jurisdictions on legislation).

Measure owner:

NDIS Strategy and Policy Division

Changes since 2026–27 Portfolio Budget Statements:

Updated program description to strengthen alignment and how it contributes to delivering Outcome 4. Revision made to the Performance Measure and target. Due to decisions held by Government to delay the rollout of aspects of NDIS reforms, both the 2026–27 Performance Measure and Key Activity were reset to align with the department's policy and legislative responsibilities. The Performance Measure has also been revised to recognise the new legislation before the Parliament to amend the *National Disability Insurance Scheme Act 2013*.

List of requirements

The Corporate Plan has been prepared in accordance with the requirements of subsection 35(1) of the PGPA Act and the PGPA Rule 2014. This table details the requirements met by the Department of Health, Disability and Ageing Corporate Plan 2026–27 and the section references for each requirement.

PGPA Rule reference	Required element	Legislative requirement	Page number(s)
s16E(2) item 1 of the PGPA Rule	**Introduction**	The following: (a) a statement that the plan is prepared for paragraph 35(1)(b) of the Act (b) the reporting period for which the plan is prepared (c) the reporting periods covered by the plan.	p.5
s16E(2) item 2 of the PGPA Rule	**Purposes**	The purposes of the entity.	p.8
s16E(2) item 3 of the PGPA Rule	**Key activities**	For the entire period covered by the plan, the key activities that the entity will undertake to achieve its purposes.	p.28-133
s16E(2) item 4 of the PGPA Rule	**Operating context**	For the entire period covered by the plan, the following:	
s16E(2) item 4(a) of the PGPA Rule	**(a) Environment**	The environment in which the entity will operate.	p.12
16E(2) item 4(b) of the PGPA Rule	**(b) Capabilities**	The strategies and plans the entity will implement to have the capability it needs to undertake its key activities and achieve its purposes;	p.17-25

PGPA Rule reference	Required element	Legislative requirement	Page number(s)
s16E(2) item 4(c) of the PGPA Rule	**(c) Risk**	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;	p.14-16
s16E(2) item 4(d) of the PGPA Rule	**(d) Cooperation**	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;	p.11
s16E(2) item 4(e) of the PGPA Rule	**(e) Subsidiaries**	How any subsidiary of the entity will contribute to achieving the entity's purposes.	Nil
s16E(2) item 5 of the PGPA Rule	**Performance**	For each reporting period covered by the plan, details of how the entity's performance in achieving the entity's purposes will be measured and assessed through: (a) specified performance measures for the entity that meet the requirements of section 16EA; and (b) specified targets for each of those performance measures for which it is reasonably practicable to set a target.	p.26-133

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