

ANZ Health Check Budget 2026–27

Overview of selected healthcare-related measures



Overview

Against the broader budget theme of resilience and reform, the key healthcare-related measures in Budget 2026-27 appear to have been largely pre-announced. The most notable measures include ongoing funding for the urgent care clinic (UCC) network in primary care, additional aged care funding for the Support at Home programme and residential aged care accommodation, and material reforms to the National Disability Insurance Scheme (NDIS).

Budget 2026-27 further embeds UCCs in the primary care landscape, provides targeted support for aspects of the Support at Home programme and residential aged care capacity, and advances a significant reform agenda aimed at improving the long-term sustainability of the NDIS.

Ahead of the budget, major industry bodies had framed their pre-budget submissions around a common set of pressures: rising demand, increasingly complex patient and client needs, persistent workforce shortages, payment systems that some argue have not kept pace with cost escalation and growing regulatory burden. The measures proposed to address these issues vary materially across sectors.

General practice and physicians are more focused on Medicare reform to facilitate longer consultations, more complex care, and improved access to primary and specialist care in rural areas. Allied health seeks stronger integration into primary care, aged care, and disability settings. Residential aged care providers are focused on capital, accommodation funding, and workforce supply, reflecting concerns about bed supply and the investment needed to address the material step-up in demand from a growing and ageing population. Childcare providers emphasise support for workforce and regulatory coherence. Private hospitals emphasise financial sustainability, benefit indexation, and keeping existing service capacity operating. Private health insurers prioritise cost containment and participation.

Against this backdrop, Budget 2026-27 is likely to be viewed as addressing selected elements of key industry priorities while leaving many broader funding, workforce, and regulatory reform proposals for future consideration.

From a service provider and business perspective, the budget is mixed.

As in previous years, a relatively small number of primary care providers stand to benefit from participating in the UCC network. In aged care, details are still forthcoming around the support for residential aged care, though if arrangements broadly reflect recommendations from the recent Accommodation Pricing review, providers with greater exposure to supported residents and those with well-advanced plans for new or expanded aged care homes may be better placed to benefit.

The primary care and aged care measures should still have modest positive effects for selected providers, particularly where funding supports operating viability, business model flexibility or the case for investment in new or expanded capacity. However, the NDIS measures stand out as the most structurally significant healthcare-related reforms announced in Budget 2026-27.

The NDIS measures are likely to have the widest implications for the broader provider market. Reforms to eligibility, planning, commissioning, and payment integrity could reshape disability provider markets over time. Larger, established, and registered providers may be better placed to adapt, given their scale, governance systems, and compliance capability. Smaller and unregistered providers may face greater adjustment pressure as the NDIS undergoes further reform, moving towards more structured assessment, tighter plan controls, expanded registration requirements, and stronger payment oversight.

The following focuses on selected key measures in Budget 2026-27.

Summary of selected key measures

Sector	Selected Budget 2026–27 measures	Initial provider/business implication
 <p>Public hospitals</p>	\$25bn additional Commonwealth funding for state and territory hospitals	Directly supports public sector capacity, and activity for the many specialists working across both public and private sector settings
 <p>Primary care</p>	\$1.8bn over five years for ongoing funding of 137 urgent care clinics (UCCs)	Further embeds UCCs as a permanent part of health infrastructure, and directly supports opportunities for a small number of selected primary care providers
 <p>Aged care</p>	\$3.7bn aged care package: up to \$1.1bn for Accommodation Supplement reform; \$349.1m for capital subsidies; \$224.3m for dementia care; \$1.4bn for Support at Home	Provides limited but targeted support for residential aged care viability, supported resident capacity, capital refurbishment/expansion; dementia transition pathways, and Support at Home affordability
 <p>Private health insurance</p>	Redirects support from higher age-based PHI rebates for older Australians into aged care: \$3bn over four years and \$1bn p.a. ongoing from 2030–31	May increase premium affordability pressure for affected older PHI policyholders, but bolsters funding for aged care capacity and access over the medium to longer term
 <p>First Nations health</p>	\$248.7m for the NHRA health schedule; \$144.1m for Aboriginal Community Controlled Health clinics and workforce housing; \$53m for remote dialysis units and accommodation; \$44.4m for Birthing on Country	Supports ACCHS infrastructure, workforce housing, remote renal care and culturally appropriate maternity care
 <p>Childcare</p>	\$17.6m for the Worker Register; \$54.8m for the Inclusion Support Program (ISP) in 2026–27; a proposed Early Education and Care Commission	Provides targeted safety, inclusion, and governance measures, rather than major new affordability measures or wage support; positive for sector integrity and inclusion capacity, but may add to compliance and admin burden
 <p>NDIS</p>	Expected savings of \$37.8bn over the forward estimates, with reforms to eligibility, planning, provider oversight, plan management, support coordination, home and living supports, payment integrity, and fraud control	Material market-shaping reforms likely to increase compliance and oversight, constrain some areas of demand growth, and favour larger, established and registered providers with stronger governance and systems capability

Selected key measures



Public hospitals

Budget 2026–27 provides a substantial uplift to public hospital funding, with \$25bn in additional Commonwealth support, including \$24.4bn through the 2026–31 National Health Reform Agreement (NHRA). This lifts Commonwealth funding for public hospital services to \$220.3bn from 2026–27 to 2030–31, covering services such as emergency departments, community health, and high-cost therapies.¹

The renewed NHRA is also being positioned as a mechanism to improve integration across health, aged care, and disability, while supporting safer and more accessible care. It includes a dedicated Aboriginal and Torres Strait Islander health schedule, supported by \$248.7m from the Commonwealth and \$200m from states and territories over five years.²

Bottom line

This is the largest direct health system funding measure. It strengthens public hospital capacity and supports state and territory health services.

For private hospitals, however, the implications are indirect and potentially mixed. A stronger public hospital system may help overall system flow, but it may also sharpen competition for workforce, patients, and elective surgery volumes. Still, there may be positive spillovers for private specialists, allied health, diagnostics, pharmacy, and other health businesses located near major hospital precincts, where increased hospital investment supports patient flows and activity.

The Budget does not yet appear to answer the private hospital sector's specific calls for hospital benefit indexation, insurer regulation, cybersecurity support or private hospital viability funding.³



Primary care

Budget 2026–27 allocates \$1.8bn over five years from 2025–26 to maintain the national network of 137 Medicare urgent care clinics (UCCs) on an ongoing basis.⁴ Operating seven days a week with extended hours, the clinics provide bulk billed treatment for urgent, non-life-threatening conditions, and are now being positioned as a permanent part of the primary care landscape. This sits alongside the existing bulk billing strategy, including \$11.4bn previously invested to incentivise bulk billing, with practice take-up appearing to be weighted more towards rural, regional, and remote areas, consistent with the weighting of the remuneration levels.⁵

The budget paper also notes that “new and amended” MBS items will ensure Medicare-eligible patients' access to safe and clinically relevant services.⁶ However, based on the information available so far, Budget 2026–27 does not appear to contain the broader GP or specialist MBS reform sought by medical bodies, such as substantial new funding for long consultations, complex chronic disease care, multidisciplinary care, or a new GP consultation structure.⁷

Bottom line

While the primary care sector continues to call for deeper Medicare reform to fund complexity, continuity, and longer consultations, the expansion of bulk billing and urgent care models reflects a continued focus on improving affordability and access for consumers.

For a relatively small number of primary care providers, UCC funding creates commercial opportunities as the urgent care model is now embedded as a permanent part of the primary care system. However, views remain mixed on the cost effectiveness of the UCC model compared with traditional general practice, and the most recent evaluation suggests the model may not yet be having a material impact on emergency department waiting times.⁸

For ordinary GP practices, the business impact remains highly dependent on billing model, patient mix, location, and cost structure. Regardless of the growth in the UCC network, overall demand for GP services is expected to remain robust, supported by population growth, ageing, and increasingly complex patient needs.⁹



Community pharmacy

Budget 2026–27 invests \$5.9bn across the forward estimates to fund new Pharmaceutical Benefits Scheme (PBS) listings and improved access to medicines. New and amended PBS listings include medicines for cystic fibrosis, chronic kidney disease and several cancers.¹⁰ This measure can also be viewed as part of a broader cost-of-living agenda, alongside earlier reductions to the maximum general PBS co-payment and the concessional co-payment freeze.

Bottom line

The Guild and other stakeholders have consistently drawn attention to consumers delaying or foregoing prescriptions due to cost-of-living pressures. New PBS medicine listings and improved access to medicines are recurring features of health budgets, but they remain important for supporting consumer affordability, medicine access, and adherence.

For pharmacies, however, the commercial impacts will depend on dispensing remuneration, medicine supply, service payments, and the Community Pharmacy Agreement (CPA) framework. Nevertheless, improved medicine access should support prescribing activity and script volumes at the margin for some pharmacies. Community pharmacies continue to benefit from the CPA framework at the federal level, which supports the core script-related business.



First Nation's health

Budget 2026–27 includes targeted First Nations health measures aimed at improving access to appropriate care, especially in remote and underserved communities. The NHRA Aboriginal and Torres Strait Islander health schedule will receive \$248.7m over five years, which will be matched by \$200m from states and territories. A further \$144.1m over two years is allocated to new or renovated Aboriginal Community Controlled Health clinics and associated health professional housing. The budget also provides \$53m over four years for remote dialysis units and accommodation in remote and very remote communities, alongside \$44.4m over four years from 2025–26 to extend Birthing on Country services.

Bottom line

These measures are targeted but meaningful access and infrastructure investments. They support Aboriginal Community Controlled Health Organisations, remote health providers, renal care, maternity services, and health workforce housing, with the potential to improve service continuity, strengthen local access, and reduce patient travel requirements.

The strongest benefits are likely to be in remote and underserved communities, where local infrastructure, workforce accommodation and appropriate models of care are critical to improving health outcomes.



Budget 2026–27 provides \$3.7bn to increase aged care supply and improve access across both residential and home care settings. The package recognises that capacity constraints are increasingly affecting older Australians’ access to care, and is intended to improve aspects of pricing, supply, affordability, and provider viability. At least some of the measures also appear to reflect elements of the recommendations from the recent Accommodation Pricing review.¹¹

The Budget allocates up to \$1.1bn over four years from 2026–27 to strengthen residential aged care pricing. The changes include increases to the base and higher Accommodation Supplements, removal of tiering within the base Accommodation Supplement, the addition of new Higher Accommodation Supplement tiers, and a new payment for services where supported residents comprise 60% or more of residents.¹²

Residential accommodation will also receive \$349.1m over four years from 2026–27 through targeted capital subsidies, commencing 1 January 2027. These subsidies are intended to support providers to expand or modernise existing homes, with additional payments of \$30 per supported resident per day for newly built homes and \$15 per supported resident per day for homes undertaking significant capacity expansion.

The budget also provides \$224.3m over four years from 2026–27 for dementia care, including a further 20 specialist dementia care units, expansion of the Hospital to Aged Care Dementia Support Program from 11 to 20 locations, and extension of the program to 30 June 2030.

For home care, \$1.4bn over four years from 2026–27 is allocated to strengthen the rollout of Support at Home and improve affordability and access. This includes \$1bn over four years to cover personal care services such as showering, continence management, and dressing from 1 October 2026.

The budget also continues aged care viability support, including funding for providers facing financial viability concerns, professional support for rural and remote providers, and early intervention support to strengthen operations, workforce, and service supply. The Aged Care Quality and Safety Commission will receive \$120.3m in 2026–27 to support its regulatory role.

Bottom line

Funding for aged care is welcome, and the package directly targets core business concerns: accommodation funding, bed supply, capital investment, dementia transition pathways, Support at Home pricing, and provider viability. However, given the scale of unmet and growing demand for Support at Home packages and residential aged care beds, the measures are likely to provide only partial relief.

Pending further implementation detail, the key question for residential aged care providers will be whether the changes to supplement and capital subsidy settings are sufficient to influence investment decisions, particularly given workforce shortages, construction costs, regulatory and compliance burdens, and uncertainty around future accommodation pricing. The target of supporting up to 5,000 beds is significant, though the pace at which incentives translate into completed capacity will ultimately depend on provider confidence, project lead times, construction market conditions, and workforce availability.¹³



Private health insurance

The Budget amends the Private Health Insurance Rebate to remove higher age-based rebates for individuals over 65. While the measure is framed as supporting intergenerational equity, it also reflects a reallocation of public funding toward aged care access. The measure has been linked to reinvestment in aged care to improve access to aged care services with \$3bn over four years from 2026–27 and \$1bn per year ongoing from 2030–31.¹⁴

Bottom line

Private health insurance membership has trended strongly upwards since the pandemic, and demand for private health insurance has historically been relatively price inelastic. While removing higher rebate levels for over-65s may increase affordability pressure for some affected policyholders, it is unlikely on its own to materially shift overall membership trends. Many affected policyholders may absorb

the higher net premium cost, given the value placed on access to private hospitals, medical specialists, dental and allied health services.

As a result, the measure is unlikely to materially affect activity driven by older PHI-funded cohorts in the near term. However, it may still be commercially sensitive for smaller insurers with older membership profiles if it affects participation or product mix at the margin.



Childcare

Budget 2026–27 includes targeted measures for early childhood education and care: \$17.6m to enhance the National Early Childhood Worker Register, as part of a broader \$226m ECEC safety package; \$54.8m for the Inclusion Support Program in 2026–27, contributing to a total of \$114m in additional ISP funding.¹⁵

The Budget also flags the creation of a national Early Education and Care Commission, consistent with the Productivity Commission’s recommendation for stronger system stewardship. Such a body would be expected to strengthen governance, oversight, and coordination across the sector.

Bottom line

The childcare measures are best characterised as a targeted safety, inclusion, and governance package. For many providers, however, the most notable issue may be what is not apparent in this budget: an extension of the Worker Retention payment arrangements, which had been widely anticipated by parts of the sector.

The announced measures respond to concerns around child safety, inclusion funding, and regulatory coherence, at a time when providers are facing unprecedented compliance and regulatory expectations. Enhanced worker registration and broader safety measures may strengthen confidence in the sector, while additional ISP funding should help some services support children with disabilities and additional needs.

For providers, a key question will be whether stronger oversight and additional inclusion funding can improve service quality and access without adding disproportionate compliance burden, particularly for smaller operators. The proposed Early Education and Care Commission could become important over time if it leads to more consistent national oversight, stewardship of supply, and better alignment between affordability, quality, workforce, and inclusion policy. However, its business impacts will depend on its mandate, powers, and interaction with existing state and territory regulators.



Budget 2026–27 includes major NDIS reforms framed as intended “to return [the scheme] to its original intent to support Australians with significant and permanent disability.”¹⁶ The reform package targets several pressure points in the scheme, including provider integrity, fraud control, eligibility, planning, service quality, provider oversight, and cost growth. It is expected to deliver \$37.8bn in savings over the forward estimates and support the National Cabinet objective of reducing annual NDIS expenditure growth to 5–6% or lower.

The reforms shift NDIS access and planning settings toward a more standardised model. From 1 January 2028, NDIS eligibility will be based on an evidence-based functional capacity assessment rather than diagnosis. New framework planning will commence from 1 April 2027, supported by \$203.8m over four years. Automatic plan rollovers and carry-forward of unspent funds will cease, and selected participation and daily activity capacity-building supports will be reset.

Provider market settings will also tighten. The National Disability Insurance Agency (NDIA) will commission a limited number of plan managers, while mandatory registration will be expanded for high-risk providers. Payment system upgrades are intended to improve integrity and user experience. A further \$200m over three years from 2026–27 will be provided for an Inclusive Communities Fund to support community-based participation activities and capacity-building activities.

Bottom line

This is one of the most consequential reforms in the budget. The NDIS reform package is not simply an integrity package; it represents a material reset of eligibility, planning, funding flows, and provider oversight.

For providers, the impacts are likely to be uneven. Larger, registered and system-ready providers may be better placed to adapt, especially where they have the governance, compliance capability and scale to operate within more formal commissioning and regulatory settings. Smaller, less formal or unregistered providers may face greater adjustment pressure as eligibility tightens, planning becomes more standardised, budgets are reset, and payment oversight increases.

The reforms are likely to reshape referral flows, pricing, compliance expectations, and demand growth across plan management, support coordination, SIL providers, allied health providers, and community participation providers.



Thriving Kids

Thriving Kids is a new foundational supports program aimed at children aged 8 and under with developmental delay and/or autism who have low to moderate support needs. The program is scheduled to begin progressively from 1 October 2026, with full implementation expected by 1 January 2028. The Commonwealth will provide \$2bn over five years, including at least \$1.4bn for states and territories to deliver services. States will contribute a further \$2bn, and the Commonwealth has also set aside \$3bn for future foundational supports.¹⁷

The program is intended to strengthen support outside the NDIS by building on mainstream health, early childhood and community service systems. Its focus is earlier identification of developmental delay and better connection of families to appropriate services outside the NDIS. Key elements include nationally consistent child development information, assistance for families to navigate services, additional community connections and support for parents of children with autism, a Medicare-subsidised health and development assessment through GPs, a National Digital Child Health Record, and upskilling for workforces involved in supporting children's development.

Bottom line

Thriving Kids should be understood as part of the longstanding, broader effort to reform the NDIS and build supports outside the scheme for children with lower-to-moderate developmental needs. It represents a significant redesign of the early childhood disability support pathway, shifting part of the response to developmental delay and autism away from individualised NDIS plans and into foundational, mainstream, and community supports.

For service providers, the reform may create new opportunities in allied health, early childhood intervention, autism support, GP-linked assessment pathways, family support, and community-based services. However, it is also expected to constrain NDIS-funded demand growth, and change pricing, referral, and commissioning arrangements.

The commercial impact will depend heavily on implementation, including whether services are commissioned through states, delivered through existing providers, funded through grants or service payments, and how workforce capacity is built across health, early childhood, and community settings.

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