National Health Genomics Policy Framework 2026 to 2030

InGeNA member assessment and implementation priorities

The final National Health Genomics Policy Framework and Implementation Plan provides a clearer national commitment to genomics in routine care. For InGeNA, the central question is how this commitment will enable timely, equitable access to genomic testing and the care it informs. This briefing assesses the response to our collective recommendations and the practical implications for members.

Our assessment is that the final strengthens the direction and several enabling conditions, particularly data principles, workforce development and community leadership. Most of our requests for specific assessment, funding and access mechanisms remain partly addressed or are not explicit commitments. The opportunity now is to shape the implementation decisions that determine whether the framework delivers change during 2026–2030.

How the final responds to our principal asks

Our ask	Assessment of the final
Measurable national access goals	Clearer routine-care ambition; no quantified national access target, including for comprehensive genomic profiling (CGP).
Fit-for-purpose assessment and a national test directory	Genomics remains within broader HTA reform; no dedicated assessment pathway or directory commitment.
Sustainable funding and consistent access across jurisdictions	Resourcing is more visible; no specified national funding mechanism, new fund or genomic NHRA funding commitment.
Transition successful research programmes into routine care	Translation remains an objective; no named transition pathway for ZERO or PrOSPeCT.
Operational industry partnerships and co-investment	Retained and elaborated; funded delivery roles and a formal industry partnership mechanism remain unspecified.
FAIR data and scalable digital infrastructure	FAIR explicitly included; a funded federated infrastructure and compliance mechanisms are not committed.
Workforce capability and service capacity	Clearer education partnerships and dedicated specialist-workforce activity; no staffing or service-capacity targets.
Consumer partnership and equitable care	Engagement and Indigenous leadership strengthened; dedicated support funding and wider population-specific targets remain open.
Accountability and delivery milestones	Foundational work and duration categories identified; detailed leads, milestones and public reporting arrangements remain to be established.

“Partly addressed” or “not committed” refers to the published framework, not to a government rejection or the absence of separate initiatives. Alignment with our recommendations does not establish that InGeNA’s feedback caused a change.

Access assessment and sustainable funding

National access goals and routine care

We asked for a measurable shift to implementation, including CGP access for cancer patients within five years and a proposed eligible-patient target by 2030. The final's vision of everyday genomic care and mission to sustainably embed high-value genomics are stronger than the draft's process-focused wording. Cancer, targeted therapies and precision medicine remain in scope, but the final does not set a CGP access target or define the service coverage Australians should expect by 2030. [F pp. 6, 8–10; C pp. 1–4, 12–13]

For members, the distinction is between an agreed direction and an operational access commitment. National goals need to identify the populations and clinical applications covered, the expected improvement in access, and the means of measuring it. Alignment with the cancer framework provides a relevant route for progressing precision oncology access.

Fit for purpose assessment and national consistency

We sought assessment and funding pathways suited to genomic technologies, including earlier access with evidence development, recognition of broader value and a national genomic test directory. Final Activity 2F continues to promote consideration of genomics within national HTA reform and supports evidence sharing and early attention to regulatory and system requirements. It does not commit to a specific assessment redesign, alternative pathway or implementation timetable. The proposed directory is not included. [F pp. 21, 24, 30, 33; C pp. 9–11, 14, 17–19]

A stocktake of tests, consistent reporting and clinical guidelines are useful, but do not provide a national mechanism for assessing, commissioning and funding genomic care. Our implementation focus should be the function the system needs to perform timely and consistent decisions that support adoption across clinical settings, informed by relevant international experience.

Funding that supports delivery across jurisdictions

We asked for a distinct funding priority, coordinated financing, public-private co-investment, a Genomics Innovation Fund, and mechanisms to address inconsistent public-hospital access. The final adds sustainable resourcing as an enabler and explicitly recognises fit-for-purpose funding models in Outcome 2.3. It retains four priorities and does not specify these funding mechanisms. The NHRA is described in the appendix; this does not constitute a commitment to embed genomic care funding in the agreement. [F pp. 6, 15, 23, 32, 65; C pp. 2, 9–10, 17–18]

Implementation needs to connect testing with interpretation, counselling, infrastructure and subsequent care. For industry and service providers, clarity about who pays, what is commissioned, and how adoption is sustained will determine the ability to invest and deliver at scale.

Transition from research to routine services

We sought structured pathways for programmes such as ZERO Childhood Cancer and PrOSPeCT to enter routine care and funding. The final retains general translation and real-world evidence provisions, but no dedicated equivalent to draft Activity 2.4.6 on integrating national pilots and research-funded programmes into clinical practice. This leaves a material gap between research investment and continuing service provision. A defined transition pathway remains a priority. [F pp. 30, 32, 43; D 2.4.6; C pp. 11, 19]

Industry partnerships data and workforce

Partnerships as a means of implementation

We asked for industry to be an integral partner in implementation, contributing to service delivery, data platforms, workforce development and co-investment. Final Activity 2G retains ethical partnerships with industry and academia, adds learning from international examples and emphasises transparency, public benefit and community priorities. These are useful foundations for collaboration. [F pp. 15, 32; C pp. 6, 12, 18–19]

This is a retained commitment rather than a new inclusion: draft Activities 2.3.2 and 2.3.3 already covered ethical models and establishing and implementing strategic partnerships. The final combines them, but implementation is less explicit. It does not define funded programmes, industry delivery roles or a formal partnership mechanism under Genomics Australia. [D 2.3.2–2.3.3; F p. 32]

The practical next step is to identify shared implementation priorities and agree contributions, governance, deliverables and adoption pathways. Success during 2026–2030 should be demonstrated through operational partnerships that improve care. Industry's contribution to horizon scanning also needs a defined route: Activity 2F draws on existing national capabilities but does not specify how industry pipeline knowledge will inform decisions. [F p. 30; C pp. 11–12]

FAIR principles and infrastructure that can scale

Our request for explicit FAIR principles is reflected in Activity 3A. FAIR means Findable, Accessible, Interoperable and Reusable. Its inclusion alongside CARE and Indigenous Data Sovereignty strengthens the basis for responsible data use across clinical and research settings. The final also more clearly links genomic information management to broader digital health reforms. [F pp. 34–36; C pp. 13–16, 19]

The full infrastructure ask is only partly addressed. Activity 3A remains a current-state assessment informing a coordinated approach; it does not commit to a funded federated system, mandatory FAIR compliance or financing across the data lifecycle. Activity 3B supports inclusion of genomics in cyber security and AI governance, without establishing a new genomic compliance regime.

For members, the implementation task is to turn principles into interoperable clinical workflows and reusable data, with clear stewardship, assurance and sustainable operating resources. Existing industry and public-sector capability should inform that work so that the stocktake leads to practical integration and investment decisions.

Education must translate into service capacity

We called for stronger links with education providers, colleges and professional bodies, alongside scalable specialist and multidisciplinary care. Final Activity 2D makes these education relationships clearer and supports a comprehensive broader-workforce strategy. Activity 2E gives specialised workforce development a dedicated activity, explicitly including genetic counsellors, laboratory scientists and bioinformaticians. [F pp. 27–29; C p. 8]

These provisions respond to important parts of our feedback. They do not specify funded posts, remuneration reform, capacity targets or scalable counselling models. Education needs to be linked to workforce availability and care pathways so that greater clinical confidence can result in timely access for patients.

Equity accountability and the next implementation decisions

Consumer partnership and equitable access

We sought genuine consumer co-design, formal advisory mechanisms and support for the services that assist patients and families before and after testing. Final Activity 1A strengthens the description of engagement, including communities with limited genomics exposure and those facing distance barriers. Activity 1B supports accessible education and connections to advocacy groups. Formal consumer and ethics/legal advisory groups under Genomics Australia and dedicated post-test or psychosocial support funding are not established in the framework. [F pp. 18–21; C pp. 6–8, 17]

Aboriginal and Torres Strait Islander leadership, cultural safety and data sovereignty are more fully articulated, including foundational governance and community-led activities. For other underserved populations, the final describes barriers and diverse patient journeys more clearly, but does not provide a comprehensive set of population-specific access targets or funded responses. Implementation should resource participation and link community-defined priorities to service decisions. [F pp. 13, 19, 25, 37–47; C pp. 16–17]

A clearer sequence but incomplete delivery commitments

The final identifies foundational activities and distinguishes time-limited projects from ongoing work. New Activity 2C considers genomic indicators for outcomes, equity, access, workforce and system performance. These improve the structure for implementation, but baselines, measures and targets are still to be developed. Individual activity leads and dated milestones are not published. [F pp. 11–12, 26; C pp. 1–2, 17]

There is also a reduction in explicit accountability detail. The draft intended annual public reporting and independent evaluation managed by Genomics Australia. The final retains Health Chief Executives Forum accountability and general monitoring and evaluation, but no longer specifies reporting frequency, public reporting or evaluation independence. These are matters to clarify early as governance arrangements are established. [D governance section; F pp. 11–12]

Summary changes in direction and structure from the Draft to the Final

Area	Consultation draft	Final and assessment
Vision and mission	Vision conditional on appropriately embedded genomics; mission centred on establishing or maintaining processes. D p. 5.	Everyday health care and sustainably embedding high-value genomics in routine care become explicit. A meaningful improvement in direction, without quantified 2030 outcomes. F pp. 6, 8.
Strategic priorities	Four priorities covering people, ecosystem, information and Aboriginal and Torres Strait Islander-led genomics.	Four retained. The first three are renamed around empowerment, a sustainable health system and responsible information management. No separate funding priority. F pp. 6, 18, 22, 34, 37.
Guiding principles	Five, including separate prevention and whole-of-system principles. D pp. 10–12.	Four. Prevention sits within a broader focus on outcomes, including ongoing treatment. Whole-system coordination is dispersed across enablers and activities rather than a standalone principle. F pp. 14–15.
Enablers	Governance, flexibility, stakeholder partnerships and international partnerships. D p. 13.	Sustainable resourcing and building on existing work become explicit enablers. International engagement

Area	Consultation draft	Final and assessment
		remains within collaboration; local flexibility remains in implementation. F pp. 11, 15.
Scope and applications	Cancer, targeted therapies, pharmacogenomics, screening and multi-omics already included. D pp. 6–8.	Adds explicit life-course framing and tumour-agnostic therapies; more direct reference to prescribers and pharmacists. These are refinements, not wholly new clinical scope. F pp. 9–10.
Presentation	Activity tables with unfilled timeframe, coordination and priority columns.	Activity identifiers become 1A–4H, with duration and foundational labels and explanations of purpose. Greater readability does not itself indicate additional delivery commitments. F pp. 19–47.

Priorities for the next phase

The framework gives us a common national basis for engagement. The following priorities would make its implementation meaningful for members and the people who need genomic care:

- Agree measurable access and equity outcomes for 2030, supported by near-term milestones, accountable leads and transparent progress reporting.
- Define assessment, commissioning and funding pathways that support routine genomic care and the transition of successful programmes.
- Translate Activity 2G into operational partnerships with agreed contributions and deliverables during this framework period.
- Connect data infrastructure and workforce development to service capacity, while resourcing consumer participation and community-led implementation.

InGeNA brings implementation experience and capability to these decisions, alongside clear advocacy on the barriers requiring government action.

References

F: Final National Health Genomics Policy Framework and Implementation Plan 2026–2030, PDF page numbers. D: July 2025 consultation draft, activity or section references. C: InGeNA NHGPF Consolidated Feedback v1.0, PDF page numbers. The detailed comparison provides the full activity crosswalk.

Framework: https://www.health.gov.au/resources/publications/national-health-genomics-policy-framework-and-implementation-plan-2026-30