

25 July 2025

Via submission portal: <https://consult.treasury.gov.au/economic-reform-roundtable-2025>

### **Catholic Health Australia Submission: Economic Reform Roundtable 2025**

Thank you for the opportunity to provide Catholic Health Australia (CHA)'s views on priority reforms to consider as part of the Roundtable process. CHA appreciates the work of the Treasury and Productivity Commission in exploring policy options to rethink how Australia's care economy can deliver care more efficiently.

CHA's submission outlines strategic recommendations focused on improving cost efficiency, embedding environmental and fiscal sustainability, enhancing workforce stability, and aligning funding models with the true cost of care. We emphasise the importance of government leadership in driving system-wide reforms through targeted investments in digital infrastructure, flexible funding models, and collaborative commissioning. Clear leadership, anchored in a shared vision, is essential to building a resilient and equitable care system. Our proposed approach aims to create a cohesive, system-wide response that delivers care more efficiently and, most importantly, returns more time to care.

We also highlight the potential for innovations such as public-private partnerships and scalable models of care, including telehealth and Hospital in the Home programs, to reduce infrastructure burden and improve both fiscal and environmental outcomes. In particular, we stress the urgency of establishing a National Private Price to improve transparency and accountability in private hospital funding and call for immediate adjustments to funding arrangements to better support regional, rural, and remote communities. We believe in the need for these reforms to funding models so that the sector can address barriers to economic sustainability and equity of access to care.

CHA welcomes the opportunity to contribute to ongoing discussions and assist in the implementation of reforms that will build a more resilient, sustainable, and equitable health and aged care system for all Australians. If you wish to discuss anything further, please contact Dr Katharine Bassett, Director of Health Policy on 0420 727 709 or at [katharineb@cha.org.au](mailto:katharineb@cha.org.au).

Yours sincerely,



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# **Catholic Health Australia**

## **Submission: Economic Reform**

### **Roundtable 2025**

July 2025

Catholic Health Australia

[www.cha.org.au](http://www.cha.org.au)

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services. CHA Members provide approximately 12 per cent of all aged care facilities across Australia, in addition to around 20 per cent of home care provision.

Our members account for over 15 per cent of hospital-based healthcare in Australia and operate hospitals in each Australian state and in the Australian Capital Territory, providing about 30 per cent of private hospital care and 5 per cent of public hospital care in addition to extensive community and residential aged care.

CHA not-for-profit providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care.

## Submission

### Background

The Australian Government is convening the Roundtable to generate fresh ideas and build consensus on reforms across three priority areas for further exploration as part of the Roundtable process:

1. **Productivity:** improve productivity by, for example, cutting red tape without lowering standards, leveraging technology and artificial intelligence
2. **Economic resilience:** build economic resilience in the face of global uncertainty – for example, attracting investment, promoting trade and security supply chains, diversifying our industrial base and building a skilled and adaptable workforce
3. **Sustainability:** strengthen budget sustainability by, for example, options to improve the structural position of the budget and fund high-quality services and priorities.

CHA understands the Roundtable process will be informed by the work the Productivity Commission (PC) is leading through its five productivity inquiries, with the goal of delivering practical and implementable policy ideas across the five pillars by the end of 2025:

1. Creating a more dynamic and resilient economy
2. Building a skilled and adaptable workforce
3. Harnessing data and digital technology
4. Delivering quality care more efficiently
5. Investing in cheaper, cleaner energy and the net zero transformation.

This submission consolidates CHA's views on the Australian Government's proposed approach to *Pillar 4: Delivering quality care more efficiently* and highlights key proposals for considerations as part of the Roundtable. It also offers broader commentary on how reforms across the health, aged care, and disability sectors can contribute to the government's overarching objectives of enhancing productivity, strengthening economic resilience, and ensuring long-term fiscal sustainability.

As Australia's largest non-government network of health, community, and aged care services, Catholic Health Australia (CHA) and its members play a leading role in the care economy. With deep experience across the sector, CHA is well positioned to meaningfully contribute to the current policy reform agenda. This submission reinforces the case for a cohesive, system-wide response that delivers care more efficiently and, most importantly, returns more time to care.

### Overall comments

CHA appreciates the opportunity to provide a comprehensive response that addresses the complex and evolving challenges facing Australia's health and aged care sectors. Our submission reflects a holistic approach grounded in the principles of sustainability, equity, and person-centred care, which we believe are essential to building a resilient system capable of meeting current and future demands.

The submission outlines strategic recommendations that span economic resilience, budget sustainability, workforce stability, and system integration. These recommendations collectively

aim to create a cohesive and adaptive care economy that prioritises efficient resource use without compromising quality or access. We emphasise that addressing these challenges requires strong and sustained government leadership, including targeted investments in digital infrastructure, adoption of flexible and responsive funding models, and the facilitation of collaborative commissioning to foster integrated care pathways. Collaborative commissioning, supported by robust data infrastructure and shared accountability frameworks, is a key enabler for achieving integrated, person-centred outcomes and maximising value for investment.

We also stress the importance of embedding environmental sustainability within the fiscal frameworks that underpin health and aged care delivery. This integration is critical to future-proofing the system against climate-related risks and operational cost pressures, while simultaneously supporting Australia’s broader net-zero ambitions. Our submission highlights innovative approaches such as optimising supply chains, supporting domestic manufacturing, and advancing scalable models of care including telehealth and Hospital in the Home programs.

Workforce stability is another foundational pillar in our recommendations. Our submission outlines the structural funding adjustments and regulatory reforms needed to empower health and aged care professionals to work at their full scope of practice, improve recruitment and retention, particularly in rural, regional, and remote communities, and foster a more sustainable and satisfied workforce. Addressing these workforce challenges is essential to ensuring that initiatives aimed at enhancing care delivery and system efficiency are effective.

Furthermore, we advocate for ongoing, transparent, and data-driven review of pricing and funding models to ensure they reflect the true cost of care delivery across diverse settings. This includes urgent reforms such as the establishment of a National Private Price, adjustments to regional funding models to guarantee equitable care access and close monitoring of the appropriateness of funding for Support at Home as it commences from 1 November 2025.

Finally, CHA underscores the necessity of a systems-wide approach that breaks down silos between health, aged care, community services, migration, housing and infrastructure policy. Our recommendations must be considered and implemented collectively to reduce the risk of reinforcing these silos that could otherwise undermine efforts to enhance productivity.

CHA remains committed to partnering with government and sector stakeholders to support the implementation of these reforms. Genuine collaboration at all levels, guided by strong leadership and a shared vision is fundamental to building a more sustainable, resilient, and compassionate care system that meets the needs of all Australians, now and into the future.

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## List of Recommendations

### Section 1: Improve the productivity of health, aged care, and disability sectors

**Recommendation 1:** Conduct a joint, cross-jurisdictional review to harmonise regulation and funding across the care sector, reducing duplication and administrative burden. Use insights to implement a risk-proportionate, outcomes-focused regulatory framework, supported by outcomes-based funding models and a National Skills and Capability Framework to optimise workforce productivity. Complement these reforms with a productivity-focused digital strategy that invests in infrastructure and coordinates existing initiatives to uplift digital capability and maturity.

**Recommendation 2:** Establish and fund pilot programs that focus on reducing low-value care and improving productivity by empowering care teams to identify bottlenecks and redesign care processes. To maximise the likelihood of success, digital innovation projects should be guided by a shared framework that includes meaningful co-design with clinicians, consumers, and carers; integration into existing workflows with appropriate support; and clear success measures with embedded evaluation. This framework should enable rapid-cycle learning, support scalability into funding and policy settings, and include mechanisms to discontinue pilots that do not demonstrate value.

**Recommendation 3:** Leverage digital transformation to drive more connected, proactive, and equitable care across the sector. This includes:

- Implementing interoperable infrastructure that integrates seamlessly across hospitals, aged care, disability services, and primary care to enable real-time data sharing.
- Investing in predictive analytics, risk stratification, and geospatial tools to support targeted care and reduce administrative burden.
- Supporting adoption through embedded digital champions, fit-for-purpose tools, and context-specific models of care.

**Recommendation 4:** Drive sustained workforce productivity through a coordinated, strategic approach to national workforce planning, supported by targeted initiatives such as migration pathways, upskilling, and team-based care models. This includes:

- Establishing a national workforce planning body with a long-term strategy that integrates health, aged care, and disability sectors, aligned with emerging models of care and digital transformation.
- Leveraging migration as a strategic tool for workforce development and growth, beyond short-term gap-filling.
- Designing funding and incentive structures that promote team-based care through development of core skills, leadership, and interdisciplinary competencies.

**Recommendation 5:** Achieving sustained productivity improvements requires addressing cultural barriers through intentional investment in structures and processes that foster trust, mutual respect, and shared purpose across care sectors and health-adjacent systems. This includes:

- Embedding principles of participatory action research into partnership models, emphasising social change, stakeholder participation, empowerment through shared knowledge, and collaborative practice.

- Ensuring federal, state, and territory governments model collaborative behaviours, aligning policy settings, objectives, and funding to reduce duplication and friction.

## Section 2: Build economic resilience in health and aged care

**Recommendation 6:** Enhance economic resilience by optimising supply chains and strengthening domestic capability in the care sector. This includes:

- Expanding domestic manufacturing of essential medicines and PPE, supported by innovation funding in biotechnology and medical research.
- Modernising inventory systems with predictive analytics and AI tools, and supporting integration into provider operations.
- Leading the transition to sustainable, circular supply models through waste reduction initiatives, expanding existing medical device and energy procurement arrangements to private hospital providers, and embedding sustainability in procurement practices.

**Recommendation 7:** Integrate health, aged care and housing policy to support a resilient care economy. This includes:

- Investing in accommodation for the care workforce, including exploring rental policy reforms such as salary packaging exemptions and rental deductions for essential workers living near their workplaces.
- Incentivising the charitable sector to repurpose vacant or underused land for care-related housing.
- Offering targeted incentives, such as tax concessions or grants, to developers building affordable, age-friendly housing.

**Recommendation 8:** Address barriers to collaborative commissioning models of care to generate operational efficiencies and optimise resource allocation. Other key actions include:

- Expanding existing initiatives through targeted grant programs that enable State and Territory governments to pilot collaborative models in high-impact regions.
- Co-designing a national policy and evaluation framework in partnership with governments and stakeholders to guide implementation and measure outcomes.

## Section 3: Strengthen budget sustainability of health and aged care sectors

**Recommendation 10:** The government should lead a coordinated effort to improve budget resilience by focusing on cost containment, billing optimisation, and capacity management. This includes investing in digital tools to reduce administrative burden, streamlining billing systems through integration, and adopting collaborative commissioning to better allocate resources. Centralised leadership and interoperable systems are essential to ensure efficiency, transparency, and sustainable care delivery.

**Recommendation 11:** The government should lead a coordinated national strategy that integrates environmental and fiscal sustainability across health, aged care, and community care sectors. This includes providing targeted financial incentives and support for private hospitals to adopt net-zero practices, investing in scalable care models like telehealth and Hospital in the Home to reduce infrastructure reliance and emissions, and establishing a digital

health innovation regulatory sandbox to accelerate sustainable technologies. Additionally, a nationally coordinated regulatory and funding framework should be developed to expand equitable access to community-based and home-based palliative care, thereby enhancing system-wide resilience, reducing costs, and supporting long-term sustainability.

**Recommendation 12:** The Government should establish a dedicated taskforce to embed financial resilience into health and aged care budget planning by developing robust contingency frameworks, incorporating real-time monitoring tools, and employing scenario-based stress testing to anticipate and mitigate risks. This approach should include building flexible funding models and adaptive infrastructure to ensure system-wide responsiveness to crises such as pandemics, climate events, and supply chain disruptions, prioritising equity and continuity of care for vulnerable populations. Embedding these practices into budget cycles will promote proactive preparedness and sustainable service delivery across the care sector.

**Recommendation 14:** Government should invest in targeted workforce stability strategies, including flexible staffing models, scope-of-practice reforms, and structural funding adjustments, to support the long-term viability of small and regional health services and ensure a sustainable, high-performing care system.

**Recommendation 15:** Government should commit to sustained, whole-of-system investment in prevention and early intervention by embedding collaborative commissioning as a standard feature of program design, addressing structural barriers to joint funding, and strengthening data infrastructure to enable real-time monitoring and outcome evaluation. This investment should be underpinned by clear, measurable indicators and supported by evaluation expertise to ensure prevention outcomes can be systematically tracked, valued, and scaled over time.

**Recommendation 16:** Government should embed public-private partnerships in future budget frameworks by addressing regulatory and structural barriers, supporting pilot programs in priority areas like virtual care and mental health, and fostering co-designed, outcome-based models that draw on the strengths of both sectors.

## Response to priority reform areas

### Section 1: Improve the productivity of health, aged care, and disability sectors

Improving the productivity of Australia's health, aged care, and disability sectors is critical to ensuring the sustainability, quality, and accessibility of care for a growing and ageing population. These sectors are facing escalating demand, rising costs, and severe workforce shortages, all of which place increasing pressure on services and staff. At the same time, structural inefficiencies, such as regulatory duplication, fragmented funding, limited use of digital tools, and underutilisation of skilled professionals, are reducing the capacity of the system to meet community needs. Lifting productivity is not about asking workers to do more with less; it is about removing the barriers that prevent them from working at their full potential, modernising outdated systems, and redesigning models of care to better support consumers and carers alike. A more productive care system designed with the considerations outlined in **Recommendation 1** will deliver better outcomes, reduce avoidable demand, and help ensure that every dollar and every hour of care delivers the greatest possible benefit.

#### **Addressing structural barriers to productivity in health, aged care, and disability**

One of the most persistent barriers to productivity is the heavy regulatory burden imposed on providers. In both health and aged care, providers are subject to overlapping compliance obligations from multiple regulators, including Commonwealth, state and territory, and professional bodies. While regulation is essential for ensuring safety and accountability, excessive or duplicative requirements divert frontline staff from direct care. In aged care, for example, the recent reform agenda has introduced hundreds of new reporting metrics, many of which lack alignment with outcomes or consumer experience. Similarly, in hospitals and general practice, administrative load, including accreditation processes, reporting, and data entry, can consume significant clinician time, contributing to burnout and reducing care capacity.

#### *Shifting towards principles-based, outcomes-focused regulation*

Reducing low-value regulatory requirements, streamlining compliance processes, and embedding digital solutions can help return time to care. A shift towards principles-based regulation, focused on outcomes and risk, would allow greater flexibility while still safeguarding standards. Governments should commit to a joint review of red tape across jurisdictions, with an emphasis on harmonisation and reducing duplication.

Greater alignment does not mean imposing a rigid, one-size-fits-all framework. Rather, it means developing a consistent foundation of principles, language, and standards that can be adapted to suit the care context. Shared outcome measures, interoperable reporting systems, and coordinated regulatory oversight would support a more person-centred and integrated system of care. This could include a common definition of quality and/or key success indicators, embedded within ongoing monitoring and reporting frameworks.

#### *Expanding scope of practice to enable team-based care*

Another key barrier is the limited scope of practice afforded to many health professionals, which constrains team-based care and undermines efficiency. In Australia, scope-of-practice decisions are often governed by rigid professional boundaries, rather than competency, training, or system need. This is particularly evident in primary care, where nurse practitioners,

pharmacists, and allied health professionals could be doing much more to manage chronic conditions, support prevention, and reduce hospital demand, but are held back by restrictive funding rules or outdated legislation.

Unlocking full scope of practice across the workforce is essential for productivity. This includes expanding access to prescribing, referrals, diagnostics, and care coordination for qualified non-medical professionals, and removing funding siloes that privilege some roles over others. For instance, enabling aged care nurses to practice at the top of their scope, supported by remote clinicians and technology, could dramatically improve access in residential care and reduce avoidable hospital transfers.

Optimising the full scope of practice, such as through the development and implementation of a National Skills and Capability Framework and Matrix,<sup>1</sup> would enhance understanding of health and aged care professionals' skills and capabilities, and support a coordinated approach to workforce planning. This would help address barriers that prevent care professionals from working to their full potential and delivering contemporary, cross-sector care. For instance, allied health professionals often face challenges transferring their skills between care sectors, leading to inefficiencies in recruitment, onboarding, and retraining. These issues are compounded by competition between sectors for a limited pool of allied health professionals, further straining workforce capacity and productivity.

#### *Embracing risk-based and adaptive regulation*

Traditional regulatory frameworks are often binary and static, based on compliance with minimum standards, rather than dynamic assessment of risk or performance. A risk-based approach would allow regulatory effort to be proportionate to the actual risk posed by a provider or service. For example, high-performing providers with strong outcomes and consumer feedback could be subject to lighter-touch oversight, while those with identified risks would receive more targeted attention. This principle is widely accepted in financial and occupational health regulation but is underutilised in health and aged care.

Embedding adaptive regulation would also allow systems to evolve as new technologies and models of care emerge. For instance, artificial intelligence in diagnostics, virtual care platforms, and new models of home-based aged care all challenge the adequacy of existing regulatory settings. A more agile regulatory framework would support innovation while managing risk in real time, not through retrospective controls.

#### *Aligning funding to outcomes across sectors*

Productivity is also undermined by structural fragmentation between funding sources, particularly between Commonwealth and state/territory governments in health, and between health and aged care systems. This misalignment creates perverse incentives and cost-shifting, with little accountability for outcomes across the full continuum of care. For example, hospitals may discharge patients quickly to avoid cost blowouts, while aged care providers lack the resources or clinical capability to manage complex needs, resulting in readmissions.

Aligning funding with outcomes, through mechanisms such as bundled payments, shared savings, or pooled budgets, can incentivise integration and productivity. These models reward collaborative, preventive care, rather than volume-based activity. In aged care, the introduction of the Australian National Aged Care Classification (AN-ACC) is a step forward, but further

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<sup>1</sup> As recommended in the *Unleashing the Potential of our Health Workforce report* (2024), accessed [here](#).

reform is needed to ensure funding reflects genuine care complexity and promotes workforce efficiency.

#### *Investing in digital infrastructure to support care*

Productivity is held back by poor digital maturity and lack of interoperability. Clinicians still grapple with manual workflows, paper records, and disconnected systems. This not only consumes time but also compromises safety. A national investment in digital infrastructure, including electronic health records, real-time data analytics, and interoperable platforms across health and aged care, would improve care coordination, reduce duplication, and enable smarter use of resources.

A productivity-focused digital strategy should go beyond infrastructure to support workforce digital literacy, embed decision support tools, and enable population-level planning and resource allocation. Harnessing data to identify gaps, benchmark performance, and target interventions is essential for a system that continuously improves.

**Recommendation 1:** Conduct a joint, cross-jurisdictional review to harmonise regulation and funding across the care sector, reducing duplication and administrative burden. Use insights to implement a risk-proportionate, outcomes-focused regulatory framework, supported by outcomes-based funding models and a National Skills and Capability Framework to optimise workforce productivity. Complement these reforms with a productivity-focused digital strategy that invests in infrastructure and coordinates existing initiatives to uplift digital capability and maturity.

#### **Piloting innovative models of care to unlock productivity gains**

Piloting innovative models of care is a critical lever to improve productivity in Australia's health and aged care systems. Rather than scaling untested reforms, well-designed pilot programs allow providers, funders, and regulators to trial new approaches in real-world settings, generate evidence of impact, and iteratively refine what works. In an environment characterised by workforce shortages, growing demand, and budgetary constraints, pilots that target low-value care, streamline workflows, and harness digital tools can deliver significant gains in efficiency, safety, and patient outcomes. **Recommendation 2** summarises the key principles and considerations for piloting innovative models of care to optimise productivity gains.

#### *Pilot programs to reduce low-value care and optimise workflow*

One of the most effective ways to improve productivity is by reducing low-value or unnecessary care — services that provide little or no benefit to patients and may even cause harm. Pilot programs that focus on de-implementation strategies, such as Choosing Wisely initiatives or decision support tools that flag unnecessary tests and procedures, can free up clinical capacity and resources for higher-value care. For instance, hospital-led trials that embed nurse-led discharge protocols, eliminate routine pre-operative tests for low-risk surgery, or use structured care pathways to reduce unwarranted variation have shown promise in reducing waste and improving flow.

In aged care, workflow optimisation pilots, such as the introduction of mobile point-of-care documentation, team huddles, and simplified medication rounds, can substantially reduce the administrative burden on staff, allowing more time for direct care. These efforts are particularly effective when combined with lean redesign methodologies and staff-led innovation.

Empowering frontline teams to identify bottlenecks and redesign care processes is key to sustainable productivity improvements.

*Pilots to ensure digital tools are co-designed and fit-for-purpose*

Digital innovation is a powerful enabler of productivity, but many technologies fail to deliver on their promise without thoughtful implementation and co-design. Pilots that are co-designed with clinicians, consumers, and carers can ensure that digital tools are fit for purpose, enhance rather than hinder workflows, and address real system pain points.

For example, trials of remote patient monitoring for chronic disease have demonstrated the potential to reduce hospital admissions, support self-management, and enable earlier intervention, provided they are integrated into existing models of care and supported by adequate training and clinical governance. Similarly, the use of artificial intelligence in radiology or pathology, natural language processing for clinical documentation, and virtual assistants for triage can significantly increase efficiency, but only if piloted in ways that build trust, ensure safety, and provide measurable gains.

Co-designed digital pilots should prioritise user experience, interoperability with existing systems, and clear metrics of success, such as reduced clinician workload, faster decision-making, or improved patient outcomes. Embedding evaluation from the outset, using a mix of quantitative and qualitative methods, ensures that learnings can inform broader system change.

*Embedding a culture of learning and scaling what works*

The real value of pilot programs lies in their ability to inform scalable reform. To unlock system-wide productivity gains, governments and funders must commit to a disciplined approach to piloting: setting clear goals, supporting rapid-cycle evaluation, and creating pathways for successful models to be scaled and embedded into funding and policy settings. Equally important is the willingness to abandon pilots that fail to demonstrate value, even if politically or institutionally popular.

This requires a cultural shift towards learning and experimentation across health and aged care systems, and a funding environment that rewards innovation, not just compliance. Creating national or state-level innovation funds, sandbox regulatory environments, and shared learning networks can support a pipeline of productive innovation.

**Recommendation 2:** Establish and fund pilot programs that focus on reducing low-value care and improving productivity by empowering care teams to identify bottlenecks and redesign care processes. To maximise the likelihood of success, digital innovation projects should be guided by a shared framework that includes meaningful co-design with clinicians, consumers, and carers; integration into existing workflows with appropriate support; and clear success measures with embedded evaluation. This framework should enable rapid-cycle learning, support scalability into funding and policy settings, and include mechanisms to discontinue pilots that do not demonstrate value.

**Harnessing data and digital technologies to return time to care**

Digital transformation is one of the most promising avenues to unlock productivity and return precious time to frontline health, aged care, and disability workers. As demand outpaces

workforce supply, the ability to use data and digital tools ethically, intelligently, and at scale is no longer optional as it is fundamental to the sustainability and safety of care. Harnessing digital innovation is not about replacing human care, but enabling it: cutting duplication, improving decision-making, supporting integration, and freeing staff to focus on what matters most. **Recommendation 3** outlines the key enablers of digital transformation to unlock these productivity gains across the sector.

#### *Ethical, safe, and clinically appropriate digital adoption*

The adoption of digital health tools, such as electronic health records, virtual care platforms, artificial intelligence, and clinical decision support systems, must be guided by ethical frameworks and grounded in clinical appropriateness. Productivity gains will only materialise when digital tools are aligned with workflow, trusted by clinicians, and centred on patient outcomes. That means engaging clinicians and consumers early in co-design, ensuring tools are explainable, safe, and evidence-based, and avoiding digital overload that can replicate or exacerbate the burdens of paperwork.

National standards and guidance, covering safety, privacy, consent, and equity of access, are essential for consistent and responsible adoption. This includes ensuring that digital innovations do not deepen the digital divide for disadvantaged populations or providers operating in resource-constrained environments.

#### *Interoperability and smarter infrastructure*

Perhaps the most obvious, and overdue, reform is the creation of interoperable digital infrastructure. Currently, the lack of real-time data-sharing between hospitals, aged care, disability services, and primary care leads to repeated assessments, missed information, medication errors, and delays in care. Seamless sharing of clinical information should be the baseline, not the exception.

CHA proposes piloting this with members that operate across health, aged care, and disability, many of whom are uniquely positioned to demonstrate the benefits of shared digital ecosystems. These pilots could trial a unified digital care record, supported by consent-based data-sharing, automatic updates from clinical systems, and alerts to flag risk across settings. The focus should be on integration that adds value, not complexity.

#### *Data-driven improvement and reduced burden*

Beyond infrastructure, there is enormous untapped potential in data analytics to support productivity. Routinely collected data should be used to identify cost drivers, reduce unwarranted variation, and inform better resource allocation across the system. Advanced analytics can spotlight overuse and underuse of services, identify populations at risk of avoidable hospitalisation, and optimise workforce deployment. This is particularly important in aged care and disability, where current systems often rely on static or retrospective reporting.

Predictive analytics, risk stratification tools, and geospatial mapping can all support more proactive, targeted care, especially when linked to real-time operational data. Embedding this capacity at the service level would enable providers to continuously improve their models of care, staffing, and service design.

### *Reducing administrative burden*

One of the most direct ways digital technologies can return time to care is by reducing administrative burden. Smart forms, voice recognition for documentation, automated reporting, and integrated rostering and workflow tools can cut hours of low-value work from the daily routine of nurses, allied health professionals, and support staff. These technologies exist, but need to be funded, supported, and tailored to the reality of care environments.

Digital tools can also enhance workforce wellbeing and retention. For example, virtual supervision, mobile access to clinical information, and remote access to training can support isolated or overstretched workers. Embedding digital champions in services, and offering ongoing training, will be key to uptake and sustainability.

#### **Case study:** Remote Patient Monitoring Program

One virtual care model supporting chronic disease management is the [Remote Patient Monitoring Program](#) operated by eHealth NSW. This Program enables healthcare professionals to assess, monitor and care for patients virtually.

The program has been rolled out in a partnership with the Agency for Clinical Innovation (ACI), NSW Local Health Districts (LHDs) and Speciality Health Networks (SHNs), and is currently supporting patients with type 2 diabetes, type 2 diabetes with chronic heart failure and chronic obstructive pulmonary disease (COPD). It exemplifies how self-administered record-keeping can be leveraged to enable virtual monitoring, allowing patients to safely receive care from home. This approach not only enhances collaboration and coordination across clinical networks but also reduces administrative burden and improves system productivity by streamlining workflows, minimising duplication, and enabling more efficient use of clinical resources.

**Recommendation 3:** Leverage digital transformation to drive more connected, proactive, and equitable care across the sector. This includes:

- Implementing interoperable infrastructure that integrates seamlessly across hospitals, aged care, disability services, and primary care to enable real-time data sharing.
- Investing in predictive analytics, risk stratification, and geospatial tools to support targeted care and reduce administrative burden.
- Supporting adoption through embedded digital champions, fit-for-purpose tools, and context-specific models of care.

### **Supporting workforce productivity through migration and upskilling**

Sustainable productivity gains in Australia's health, aged care, and disability sectors cannot be achieved without addressing the deepening workforce crisis. Chronic shortages, ageing demographics, increased care complexity, and global competition for skilled workers are converging to place unprecedented strain on the system. Boosting workforce productivity requires both short-term relief and long-term structural reform — strategies that span migration, education, upskilling, and workforce redesign. **Recommendation 4** calls for a unified national vision for workforce sustainability, underpinned by strategic planning, system integration, and long-term investment in capability.

### *National workforce planning*

Australia lacks a coherent, long-term health workforce strategy that brings together health, aged care, and disability under a single coordinated approach. These sectors are not only competing with each other for the same workforce but also with other countries facing similar challenges. Health Workforce Australia (HWA), or a similar national workforce planning body, should be reestablished to ensure the care workforce meets the current and future healthcare needs of the population, through planning, coordination and policy advice. This workforce planning body would collate, analyse, and utilise workforce data from the health, aged care, and disability sectors to inform evidence-based policies and strategies, enabling decision-makers to proactively and efficiently adapt to changing healthcare demands and ensure that all Australians have access to high-quality healthcare.

HWA, or similar, should also use this data to produce evidence-based national supply and demand projections for various professions based on a range of alternative planning scenarios. This will ensure that Australia has a care workforce, with the right skills and in the right locations, to meet community needs and demand. In addition to its functions in research, planning, and coordination, the workforce planning body should assist with reducing the state-based politicisation of workforce and training incentives in the short term. It is known that this practice has inevitably meant that workforce gaps have been traditionally shifted between states and territories as opposed to being addressed.

### *Migration as a strategic lever, not a stopgap*

Migration plays a vital role in alleviating immediate workforce gaps, but it must be embedded within a broader national strategy, not treated as a stopgap. Australia is competing globally for a limited pool of skilled health and care professionals. To remain competitive, migration settings must be streamlined, prioritised for high-need roles, and coordinated with domestic training pipelines. This includes reforming visa pathways, recognising international qualifications more efficiently, and improving onboarding and retention supports for internationally qualified workers.

A national workforce planning body could guide migration policy to ensure it is responsive to real-time data and labour market gaps, especially in underserved rural, remote, and aged care settings. Migration should complement, not replace, domestic upskilling and training; both are essential for system resilience.

### *Upskilling and redesigning models of care*

Improving workforce productivity also hinges on upskilling the existing workforce and enabling smarter, team-based models of care. Investment in skills development, particularly digital literacy, leadership, and interdisciplinary competencies, is essential to prepare the workforce for evolving models of care that are increasingly virtual, data-driven, and consumer-directed.

Task reallocation, that is shifting appropriate tasks from higher- to lower-skilled staff or between professions, can significantly improve care efficiency and job satisfaction. For instance, trained care workers or allied health assistants can take on routine monitoring, documentation, or support tasks, freeing up nurses and clinicians to focus on complex care. Enabling these models requires regulatory flexibility, supportive supervision structures, and adequate funding for training.

Team-based care, where professionals work collaboratively across disciplines and scopes of practice, has been shown to improve outcomes and reduce duplication. For this to be embedded at scale, workforce planning must include the design of funding and incentive structures that support team care in all settings, not just in hospitals or pilot programs.

#### *Building digital capability across the workforce*

Digital transformation is central to improving productivity, but without investment in workforce digital capability, new technologies risk being underused or resisted. Workforce strategies must include large-scale digital literacy programs, support for clinical informatics leadership, and co-design of tools that integrate seamlessly into workflows. Clinicians and carers must be partners in the digital transition, with training tailored to their roles and responsibilities.

Additionally, digital tools such as telehealth, remote monitoring, clinical decision support, and AI-enabled triage, can enhance workforce reach, reduce duplication, and improve care safety. Their adoption must be matched with clear role definitions, governance frameworks, and incentives aligned to outcomes.

**Recommendation 4:** Drive sustained workforce productivity through a coordinated, strategic approach to national workforce planning, supported by targeted initiatives such as migration pathways, upskilling, and team-based care models. This includes:

- Establishing a national workforce planning body with a long-term strategy that integrates health, aged care, and disability sectors, aligned with emerging models of care and digital transformation.
- Leveraging migration as a strategic tool for workforce development and growth, beyond short-term gap-filling.
- Designing funding and incentive structures that promote team-based care through development of core skills, leadership, and interdisciplinary competencies.

#### **Addressing cultural barriers to productivity**

Cultural and organisational differences can hinder collaboration and reduce productivity. The health, aged care, disability, and community sectors each operate with distinct practices, professional languages, and success metrics. Building trust and mutual understanding takes time, especially when organisations have previously competed for funding or worked in isolation. Power imbalances, such as those between government agencies and small community-based organisations, or between funders and providers, can further strain partnerships or intensify challenges related to competing priorities. These dynamics can undermine collaborative models like commissioning or public-private partnerships (see subsequent sections). When partnerships are perceived as top-down or tokenistic, they risk disengagement and resistance from stakeholders.

To address this, Australia must invest in structures and processes that intentionally foster trust, mutual respect, and a shared purpose across the care sectors and related health-adjacent systems. **Recommendation 5** articulates these key considerations to address these barriers. One practical approach is through embedding the principles of [participatory action research](#) as the foundation for all partnership models. These principles should include:

- **An emphasis on driving social change:** aimed at enabling action that leads to meaningful improvement on a specific issue by aligning evidence-based strategies with real-world application.

- **Stakeholder participation:** projects are shaped and guided by the active involvement of individuals, communities, and organisations with a direct interest in the issue, ensuring relevance and shared ownership.
- **Empowerment through shared knowledge:** emphasises a democratic model of collective learning, where knowledge is intentionally co-created, owned, and applied by stakeholders, which empowers all participants and informs better decision-making.
- **Collaborative practice:** collaboration is integrated across the entire project lifecycle, from initial planning and design through to implementation and evaluation, ensuring all partners contribute meaningfully and share in the benefits generated through the partnership.

Importantly, the federal and state and territory governments must model collaborative behaviours themselves, aligning policy settings, objectives, and funding where possible to reduce duplication and friction. When governments, funders, and providers work together with mutual respect and shared goals, partnerships are more likely to succeed, be perceived as genuine rather than tokenistic, and deliver clear, measurable improvements in productivity.

**Recommendation 5:** Achieving sustained productivity improvements requires addressing cultural barriers through intentional investment in structures and processes that foster trust, mutual respect, and shared purpose across care sectors and health-adjacent systems. This includes:

- Embedding principles of participatory action research into partnership models, emphasising social change, stakeholder participation, empowerment through shared knowledge, and collaborative practice.
- Ensuring federal, state, and territory governments model collaborative behaviours, aligning policy settings, objectives, and funding to reduce duplication and friction.

## Section 2: Build economic resilience in health and aged care

A resilient and adaptive health and aged care system relies on robust operational foundations, including effective management, strategic workforce planning and training, integrated information systems, and streamlined procurement and supply chains, all while addressing the broader social determinants of health through coordinated, cross-sectoral approaches. Strengthening economic resilience in the care and adjacent sectors, requires targeted financial incentives that enable services to strengthen these capabilities within their local contexts. This includes addressing region-specific challenges, such as workforce attraction and retention in rural, regional, and remote areas, to ensure equitable implementation across diverse settings. To support this, governments must also work to reduce fragmentation across jurisdictions and align efforts between public and private sector providers.

### Unlocking economic opportunity through supply chain optimisation and domestic capability

There is significant opportunity for governments to strengthen economic resilience in the health and aged care sectors by optimising supply chains and enhancing domestic manufacturing capabilities. Specific options to optimise supply chains and enhance domestic manufacturing capability has been detailed in **Recommendation 6**.

Outcome 1.4 of the Health National Adaptation Plan highlights the importance of resilient health infrastructure and supply systems, signalling a strategic shift toward more sustainable and secure models. As part of this, the sector is increasingly recognising the value of transitioning to a circular economy for essential medical supplies, such as medicines and personal protective equipment (PPE), to enhance continuity of care and preparedness during supply chain disruptions.

#### *Enhance domestic manufacturing capability*

Government could enhance the domestic manufacturing capability to best deliver essential medicines and PPE with a view to reduce the care sector's reliance on importation. This may involve strengthening initiatives identified in the Medical Science Co-investment Plan through grant funding opportunities. Investment into strategic alliances at the national level, similar to the Melbourne-based pilot of the [Australian Medtech Manufacturing Alliance \(AMMA\)](#), could bring together key industry bodies to address procurement barriers facing the care sector.

In parallel, government could leverage existing national funding mechanisms, such as the [Medical Research Future Fund](#) or the [National Reconstruction Fund Corporation](#), to drive innovation in biotechnology and medtech while supporting the growth of domestic manufacturing infrastructure. Aligning these efforts with broader health system priorities would not only improve supply chain resilience but also foster a more agile and self-sufficient healthcare sector capable of responding effectively to future public health challenges.

#### *Modernise inventory management systems*

Government could further reinforce the benefits of predictive analytics and AI-driven tools in inventory management to help health and aged care services anticipate shortages and respond swiftly to market fluctuations. These technologies are particularly valuable in enhancing emergency response preparedness and enabling rapid scaling of key public health initiatives. For example, during the COVID-19 pandemic, predictive inventory systems were crucial in managing the distribution of PPE, ensuring frontline workers had timely access to essential supplies despite global disruptions. Supporting care providers to embed such capabilities into operational foundations would further strengthen the sector's resilience and responsiveness in both routine and crisis scenarios.

#### *Lead transition to secure, low-emissions and circular supply models*

There is a strategic opportunity to lead the transition of the care sector toward secure, low-emissions, circular supply models. These models reduce waste, improve supply chain reliability, and support local economic development, which are key pillars of a resilient and sustainable care economy. The hospital sector stands to achieve meaningful cost savings while significantly contributing to emissions reduction through targeted efforts to minimise freight-related emissions. This can be achieved by prioritising local suppliers and evaluating vendors based on their sustainability reporting metrics. Such practices not only lower environmental impact but also enhance supply chain transparency and reliability.

Government has a clear role in endorsing and incentivising shared procurement contracts within the not-for-profit hospital sector. By encouraging or endorsing partnerships with sustainable, local suppliers, these initiatives can unlock sector-wide economic benefits. This includes job creation through local sourcing, increased leverage over manufacturers to disclose and improve sustainability practices, and greater resilience against global supply disruptions.

CHA members note that some contracts between State and Territory governments and public hospital providers are already in place. Expanding these arrangements to include willing private hospital providers, who are significant stakeholders in medical device and energy procurement, would present a valuable opportunity to scale sustainability efforts across the entire sector. Such collaboration would not only strengthen supply chain resilience but also drive consistent progress toward national sustainability goals.

Optimising the medical supply chain is not just an environmental imperative, but a strategic economic move. By embedding sustainability and localisation into procurement practices, the health and aged care sectors can collectively build a more agile, responsive, and economically resilient foundation for future public health challenges.

**Recommendation 6:** Enhance economic resilience by optimising supply chains and strengthening domestic capability in the care sector. This includes:

- Expanding domestic manufacturing of essential medicines and PPE, supported by innovation funding in biotechnology and medical research.
- Modernising inventory systems with predictive analytics and AI tools, and supporting integration into provider operations.
- Leading the transition to sustainable, circular supply models through waste reduction initiatives, expanding existing medical device and energy procurement arrangements to private hospital providers, and embedding sustainability in procurement practices.

### **Integrating housing and infrastructure policy to support workforce participation**

Genuine health and wellbeing begin with access to secure, affordable housing that meets the care needs of its residents. In line with CHA's ethos, Catholic organisations, civil society, and governments share a moral imperative to address the housing crisis and rising homelessness, with a particular focus on supporting the most vulnerable in our communities. CHA's position on housing and homelessness policy is available [here](#).

Government must better integrate health and housing policy to support a resilient care workforce. An integrated approach to health and housing policy will also help address the increasing number of older people falling through the cracks at the interface of housing, health and aged care. This section outlines the specific impacts of housing insecurity on the care sector and proposes targeted solutions as summarised in **Recommendation 8**, including investment in worker accommodation, housing subsidies, increasing the supply of affordable housing, and partnerships with the community housing sector.

#### *Address housing challenges to improve care workforce stability*

Many regions face persistent challenges in attracting and retaining healthcare professionals, with rising housing costs emerging as a major barrier. Nurses and other health and aged care workers often struggle to afford housing near their workplaces, leading to long commutes or relocation to more affordable areas. For example, in metropolitan areas, many well-established hospitals are located in suburbs where affordable housing is scarce. This issue extends beyond major cities to regional and rural communities, further exacerbating workforce shortages. As a result, essential workers are forced to travel significant distances, contributing to fatigue and, in some cases, reduced working hours.

CHA recommends that Government immediately explore with a view to implement, rental policies including exemption from salary packaging caps and rental deductions up to a certain limit for properties located within a certain proximity to work for essential workers in health and aged care. This investment from the Commonwealth Government would provide a pay advantage to a workforce that is lagging behind general market rates for equivalent university graduate roles and struggling to attract new entrants. It would also help not-for-profit healthcare providers overcome a key recruitment barrier. Additionally, by incentivising nurses to work at local facilities, it could reduce the appeal of leaving stable positions for costly agency roles.

This program could be piloted in select regions to assess the effectiveness and feasibility of the program. Clear eligibility criteria would need to be established for nurses to qualify for rent subsidies to ensure the program targets those most in need. A robust monitoring and evaluation framework would be required to ensure the program is sustainable and prevent distortion of the local housing market.

#### *Address housing insecurity to improve health outcomes for older Australians*

Older Australians facing housing insecurity are disproportionately affected by poor health outcomes, social isolation, and financial stress. Limited access to affordable, age-appropriate housing exacerbates existing vulnerabilities, making it harder to manage chronic conditions, maintain independence, and engage with community services.

As the demand for home care continues to grow, most older Australians express a strong preference to receive support in their own homes. However, persistent waitlists for home care packages mean many are unable to access the level of assistance they need as their care requirements evolve. This gap in support often forces individuals into unstable living situations, increasing the likelihood of hospitalisation, mental health deterioration, and a diminished quality of life. These impacts place additional strain on the health, aged care, and disability sectors, highlighting the urgent need for integrated solutions.

To build economic resilience across these sectors, government must prioritise coordinated pathways that enable health, aged, and social service providers to better meet individuals' needs. This includes partnering with key organisations to identify and reduce the barriers and costs associated with developing social, affordable, and crisis housing. Incentivising the charitable sector, repurposing vacant or underused land, and expanding initiatives like the Housing Australia Future Fund with dedicated allocations for age-friendly housing – would help increase the supply of appropriate housing for vulnerable older Australians.

#### *Prioritise preventative health approaches*

Alternatively, government should prioritise preventative health by incentivising housing initiatives that address the complex needs and health experiences of vulnerable populations. Integrating health considerations into housing design and planning can reduce long-term care costs and improve overall wellbeing.

To support this, targeted incentives, such as tax concessions or grants, could be offered to developers constructing affordable, age-friendly housing. These measures would encourage long-term investment in housing solutions that promote health equity and support ageing in place for older Australians. Specific initiatives could include:

- design and implementation of grant funding of up to \$2 million as a contribution to builds targeting affordable housing for older people, carefully designed so as not to just increase prices and profits of developers
- tax reform or grants to encourage the ongoing growth of build-to-rent housing for long-term rental
- request a Productivity Commission review of tax policy settings impacting long-term housing and homelessness outcomes with a view to identify options to address these impacts.

**Recommendation 8:** Integrate health and housing policy to support a resilient care economy. This includes:

- Investing in accommodation for the care workforce, including exploring rental policy reforms such as salary packaging exemptions and rental deductions for essential workers living near their workplaces.
- Incentivising the charitable sector to repurpose vacant or underused land for care-related housing.
- Offering targeted incentives, such as tax concessions or grants, to developers building affordable, age-friendly housing.

### **Advancing collaborative commissioning to address social determinants of health**

Collaborative commissioning, where stakeholders co-design, fund, and deliver health and social care services, provides a strategic pathway to improving outcomes, reducing fragmentation, and enhancing value for investment. By aligning services around an individual's full spectrum of needs, including physical, mental, and social needs, it fosters more coordinated, person-centred care. Specific actions to advance collaborative commissioning is set out in **Recommendation 9**.

This model is particularly effective in areas such as chronic disease management, where integrated efforts across primary care, hospitals, and community services can reduce avoidable hospital admissions and improve quality of life. Importantly, by streamlining service delivery and minimising duplication, collaborative commissioning generates operational efficiencies. These efficiencies free up resources that can be redirected toward addressing broader social determinants of health, such as housing, nutrition, and social connection, which are critical to long-term health and wellbeing.

Despite its potential, embedding collaborative commissioning as standard practice faces persistent barriers, including fragmented funding and governance, limited data-sharing and system interoperability, and rigid regulatory frameworks. Overcoming these challenges is essential to unlocking the full potential of this model and enabling a more holistic, equitable approach to care.

CHA's submission to the Productivity Commission (available [here](#)) outlines these challenges in depth, while also identifying clear opportunities to better integrate funding and planning across the health, aged care, and community sectors. Addressing key barriers, particularly the absence of cohesive funding models and strategic oversight, would help create a policy environment that enables providers to focus on delivering high-quality, wraparound care. Such reforms would not only optimise resource allocation and improve operational efficiency but also build capacity to deliver more place-based, person-centred support for marginalised communities.

Government should expand existing collaborative commissioning initiatives by establishing grant programs that enable State and Territory governments to pilot these models in regions with the greatest potential for impact. Funding arrangements should be flexible and tailored to local contexts, with eligibility criteria aligned to key principles such as data-sharing, cross-sector cooperation, and sustained engagement.

Importantly, Government must adopt a leadership role in fostering sector-wide confidence in collaborative commissioning. This includes co-designing a policy framework, supported by an evaluation framework, with State and Territory governments, and key care sector stakeholders. The policy framework should establish shared indicators of success, such as health equity, service integration, patient-reported outcomes, and system efficiency, while allowing flexibility for local innovation and priorities. These indicators should prioritise and encourage person-centred outcomes that reflects the goals of integrated care, including but not limited to improved patient experience, reduced avoidable hospitalisations, increased capability-building, or advancing continuity of care. Each indicator should be assessed against established evaluation criteria to generate meaningful insights that can be shared with participants. This process also supports embedding accountability throughout collaborative commissioning.

**Case study: Local Health Service Networks Policy Framework**

The Victorian Department of Health have recently released their [policy framework](#) to support the establishment of Local Health Service Networks – which sought to address the fragmented nature of independent health services by encouraging greater accountability and providing more robust monitoring and oversight.

The framework identifies several key principles to guide the design, establishment, operation and oversight of these Networks:

- Prioritisation of patient choice to receive care as close to home as possible, whilst balancing safety and complexity.
- That care is easy to navigate and provided equitably along logical pathways, understanding how communities travel and interact.
- Ensuring that health service sites have clear roles and responsibilities for different levels of service provision, aligned to their scale and capability.
- Enhanced patient and community engagement to support local customisation and responsiveness to community need.
- That a skilled and diverse workforce is attracted, retained and supported, including through collaboration on recruitment, training and research.
- Care pathways are seamless, with greater integration across primary, acute and aged care, Aboriginal health, mental health and alcohol and other drug services.
- The health services system is accountable, collaborative, transparent and informed, to support the outcomes that matter to patients.
- Resources are used effectively, minimising unnecessary duplication and administration to deliver value for Victorians.
- The health services system continuously improves and is flexible and adaptable in response to change.

Importantly, the policy framework articulates a plan for developing an outcomes framework, reporting and accountability structures, and initiatives to transition from existing partnership arrangements. While its implementation has yet to be evaluated for effectiveness, it offers a

foundational starting point for Government seeking to invest in and support similar collaborative commissioning models.

**Recommendation 9:** Address barriers to collaborative commissioning models of care to generate operational efficiencies and optimise resource allocation. Other key actions include:

- Expanding existing initiatives through targeted grant programs that enable State and Territory governments to pilot collaborative models in high-impact regions.
- Co-designing a national policy and evaluation framework in partnership with governments and stakeholders to guide implementation and measure outcomes.

### Section 3: Strengthen budget sustainability of health and aged care sectors

#### Ensuring budgetary resilience via cost efficiency

There is a significant opportunity to strengthen budgetary resilience across the health and aged care sectors by strategically coordinating efforts to improve operational efficiency. A system-wide approach, spanning multiple providers and components of the care economy, can deliver meaningful fiscal sustainability through targeted strategies such as cost containment, billing optimisation, and capacity management. Government leadership is critical in driving these improvements – such as in setting interoperability standards, negotiating vendor contracts, and investing in digital tools and infrastructure that deliver measurable value aligned with strategic outcomes and long-term financial sustainability. **Recommendation 10** calls for a government-led, system-wide approach to enhance budgetary resilience through cost containment, billing optimisation, and capacity management across health and aged care sectors.

##### *Cost containment*

Cost containment in this context must be carefully balanced with the imperative to deliver safe, high-quality care. Reducing unnecessary expenditures, such as duplicative administrative tasks like entering similar data across multiple platforms, can free up resources without compromising care outcomes. Emerging technologies offer practical solutions, such as automated clinical notetaking assistants that integrate seamlessly into existing workflows, or speech-to-text electronic medical record systems, which demonstrate the potential for reducing clinician burden and improving documentation accuracy.

Given the proliferation of digital tools and software solutions in the market, there is a clear opportunity for government leadership in this space. By centralising contract negotiations with software vendors and guiding implementation efforts, the government can leverage its scale and evaluative capabilities to ensure value for money. This includes assessing vendor performance against defined criteria such as interoperability, user experience, and measurable impact on efficiency.

##### *Billing optimisation*

Streamlined and fit-for-purpose billing processes are essential to ensuring accurate revenue capture and reducing administrative burdens across the aged care sector. Integrated billing platforms, real-time analytics, and user-friendly portals can drive improvements in operational efficiency while enhancing transparency and accountability.

An example of system integration would be the integration of Services Australia with aged care providers, which offers a clear opportunity to streamline billing and financial updates for older Australians receiving government-subsidised care under Support at Home. This would reduce duplication, improve billing accuracy, and enhance transparency across the care journey. This clarity is critical to ensuring that each stakeholder is accountable for their part in the care and billing process, ultimately fostering trust and improving service delivery.

Initiatives like system integration require targeted investment in scalable, adaptable digital infrastructure to suit diverse care contexts. To ensure consistency and avoid fragmentation, these efforts should be Government-led, such as in setting standards, guiding implementation, and ensuring systems are interoperable. Strategically, such leadership could help prevent future cost blowouts while laying the foundation for a future-proofed, digitally enabled healthcare system.

### *Capacity management*

Effective capacity management is essential for ensuring care delivery meets rising demand without exceeding resource limits. As health systems face workforce shortages and budget constraints, strategic use of existing resources is key to building long-term budgetary resilience.

As highlighted in CHA's submission to the Productivity Commission (available [here](#)), collaborative commissioning offers a promising pathway to improve capacity management by integrating models of care provision around the needs of individuals and communities. By moving beyond siloed decision-making, it fosters meaningful collaboration among government agencies, health services, community organisations, private providers, and consumers, serving as a strategic mechanism for optimising capacity management across the care system.

Importantly, central oversight is essential to ensure capacity management strategies are aligned with the broader reform agenda and implemented consistently across the system. Lessons learnt from health-adjacent sectors could also be applied to support the implementation of these strategies.

**Recommendation 10:** The government should lead a coordinated effort to improve budget resilience by focusing on cost containment, billing optimisation, and capacity management. This includes investing in digital tools to reduce administrative burden, streamlining billing systems through integration, and adopting collaborative commissioning to better allocate resources. Centralised leadership and interoperable systems are essential to ensure efficiency, transparency, and sustainable care delivery.

### **Integrating environmental and fiscal sustainability in care delivery**

There are distinct funding models, structures and strategic priorities between health, aged care, community care and those that operate across all of these areas. This presents challenges to implement key environmental and fiscal sustainability initiatives in a coordinated manner across organisations.

Limited financial resources restrict the ability of the NFP sector to undertake large-scale projects, such as joint procurement to optimise the medical supply chain and minimise medical waste as set out in a previous section. There remains a risk that sustainability compliance measures become increasingly enforced, without the supporting mechanisms for implementation.

There is an opportunity for Government to strategically direct a cohesive and systemic response that integrates environmental and fiscal sustainability in care delivery across the public health, not-for-profit health, and aged care sectors. This will ensure that the care economy can collectively progress climate and health adaptation activities while prioritising budgetary resilience. **Recommendation 11** calls for a government-led, integrated strategy that aligns environmental and fiscal sustainability across health, aged care, and community care sectors.

#### *Incentives to support private hospital sector to transition to net zero*

Hospitals are responsible for approximately half of the healthcare sector's total emissions, driven by intensive energy use for heating, cooling, and powering medical equipment, as well as emissions from waste management and anaesthetic gases. Within this context, private hospitals represent a substantial portion of the sector's infrastructure and service delivery. They play a vital role in Australia's healthcare system by providing essential capacity and resources that complement and alleviate pressure on the public sector.

Given their scale and influence, private hospitals are uniquely positioned to lead and accelerate the sector's transition to net zero. Supporting these institutions in adopting sustainable practices is not only critical for achieving national emissions targets but also for ensuring the long-term resilience and fiscal sustainability of healthcare delivery. By investing in capability uplift and environmental innovation within the private hospital sector, the Government has a strategic opportunity to drive systemic change, reducing operational costs, improving patient outcomes, and fostering a more sustainable healthcare ecosystem.

To drive meaningful environmental change at the service level, Government support and leadership is essential, particularly given the context of financial constraints faced by private hospitals. Establishing a targeted scheme to empower sustainability advocates within the private hospital sector could unlock significant cost-saving opportunities. By offering financial incentives for implementing low-cost, high-impact sustainability measures within routine operations, the scheme would demonstrate immediate value while building organisational readiness for larger-scale initiatives. Government could also look to subsidise costs for hospitals to track and report against sustainability targets for the sector, similar to those outlined in the [National Health and Climate Strategy](#). This approach ensures that environmental leadership is supported at all levels as a driver for long-term fiscal sustainability.

#### *Scalable models of care to address infrastructure burden and reduce capital costs*

Telehealth and Hospital in the Home (HiTH) programs can provide clinically appropriate, timely, and more accessible care for patients while reducing travel emissions. These approaches not only enhance patient outcomes but also contribute to environmental and fiscal sustainability.

There is a strategic opportunity for government to invest in a digital health innovation regulatory sandbox. This pilot would allow providers to test integrated digital solutions, such as shared care records, AI-enabled care planning, and telehealth, within a streamlined regulatory environment. By reducing regulatory fragmentation, the sandbox could accelerate digital adoption, improve data interoperability, and enhance clinical outcomes.

A large-scale telehealth model, implemented iteratively, would enable rapid scaling of insights from existing initiatives to better meet evolving community needs. By shifting care delivery away from traditional brick-and-mortar facilities, telehealth reduces reliance on physical infrastructure, minimising the need for new buildings, inpatient beds, and associated

overheads. This translates into lower long-term capital costs while supporting both environmental sustainability and broader access to care.

**Case study:** Virtual Nursing in Aged Care

The Department of Health, Disability and Ageing has launched a pilot initiative to embed virtual nursing support into 30 residential aged care homes, operating 24 hours a week with Registered Nurses (RNs) and a Nurse Practitioner available remotely. The pilot is funded through to 30 June 2027, with La Trobe University leading an evaluation to inform future government decisions.

The virtual care model provides real-time access to experienced nursing professionals, supporting on-site staff with case management, clinical decision-making, and resident care. Importantly, the model is not limited to resident-initiated contact; it empowers staff to seek guidance when needed, fostering a culture of continuous learning and support.

The eligibility criteria for participating homes were based on their location in regional, rural and remote areas, meeting threshold limits that demonstrate challenges in meeting care minute and RN minute requirements, and had a high reliance on agency staff. This targeted approach ensures the model reaches facilities most in need. However, the criteria also raise important questions about broader applicability. Many metropolitan homes face similar workforce shortages and could benefit from scalable virtual support models.

Importantly, this pilot articulates structured training being provided to on-site staff to effectively use virtual tools – with a continued emphasis that these virtual tools are complementary to existing workflows. By equipping staff with the skills to engage confidently with virtual care systems, the model enhances workforce capability and retention.

CHA believes that this pilot represents a promising intersection of health and aged care innovation. With strategic funding, it has the potential to transform nursing support across the sector, improve outcomes for residents, and strengthen the aged care workforce.

Despite their potential, out-of-hospital care and HiTH remains underdeveloped and has been described as the “missing sector” in Australia’s care economy. Private health insurers have estimated that expanded HiTH could save the private health system \$1.3 billion per year.<sup>2</sup> Evidence shows that HiTH leads to lower readmission rates, shorter lengths of stay, reduced mortality, and increased patient satisfaction<sup>3</sup> - making it a more efficient and effective alternative to traditional inpatient care. However, the absence of a nationally coordinated strategy and incentive framework has hindered widespread adoption. Government investment in scalable, preventative models like HiTH is essential to unlock their full value and embed sustainability into the future of healthcare delivery.

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<sup>2</sup> There’s no place like home: Reforming out-of-hospital care (2023) Private Healthcare Australia. Available at: [https://www.privatehealthcareaustralia.org.au/wp-content/uploads/20230523\\_PHA-Report\\_Reforming-out-of-hospital-care.pdf](https://www.privatehealthcareaustralia.org.au/wp-content/uploads/20230523_PHA-Report_Reforming-out-of-hospital-care.pdf)

<sup>3</sup> Out of hospital care in Australia (2021) Catholic Health Australia. Available at: <https://www.cha.org.au/wp-content/uploads/2021/03/6-CHA-Report-J170720.pdf>; and Cross, J., et al (2020). ‘Supporting choice: an innovative model of integrated palliative care funded by a private health insurer.’ *Internal Medicine Journal*, 50(8), pp.931-937.

Home-based palliative care offers a yet another sustainable, cost-effective alternative to inpatient services, especially as Australia's population aged 85+ continues to grow. Yet access remains uneven, with rural and regional communities facing significant barriers, and care models vary widely across settings and jurisdictions. A nationally coordinated approach to regulation and funding is essential to ensure equitable access, reduce reliance on high-cost infrastructure, and support environmental and fiscal sustainability through investment in scalable, community-based care.

**Recommendation 11:** The government should lead a coordinated national strategy that integrates environmental and fiscal sustainability across health, aged care, and community care sectors. This includes providing targeted financial incentives and support for private hospitals to adopt net-zero practices, investing in scalable care models like telehealth and Hospital in the Home to reduce infrastructure reliance and emissions, and establishing a digital health innovation regulatory sandbox to accelerate sustainable technologies. Additionally, a nationally coordinated regulatory and funding framework should be developed to expand equitable access to community-based and home-based palliative care, thereby enhancing system-wide resilience, reducing costs, and supporting long-term sustainability.

### **Embedding resilience in budget planning**

Given significant market and economic volatility, there is a need to embed resilience in budget planning to ensure the sustainability and responsiveness of Australia's health and aged care systems. This includes building financial buffers, adopting flexible funding models, and aligning resource allocation with emerging demographic trends, workforce pressures, and evolving care needs across diverse communities. **Recommendation 12** calls for a government-led taskforce to strengthen health and aged care budget resilience through flexible funding, real-time monitoring, and scenario planning, ensuring the system can adapt and maintain quality care during crises.

#### *Government leadership and learning from crises*

There is an opportunity for government to build on lessons learned from the resource intensity and rapid shifts during the COVID-19 pandemic to better prepare for future crises. This may involve establishing a dedicated taskforce of subject matter experts to develop robust contingency planning approaches to embed budgetary resilience. As part of these efforts, real-time monitoring tools and dynamic dashboards should be implemented to identify and allocate surge capacity, both in resources and workforce, across care settings.

The care sector must be equipped to respond to a wide range of disruptions, including pandemics, climate shocks such as extreme weather events, and global interruptions to supply chains or workforce migration. To support this, government could take the lead in implementing adaptive infrastructure that strengthens system-wide resilience. Such infrastructure would help safeguard care continuity and promote equity, particularly for vulnerable populations, including, but not limited to, older Australians, people living in regional, rural and remote communities, and Aboriginal and Torres Strait Islander peoples.

Furthermore, the government-led taskforce could employ scenario planning tools to stress-test budget frameworks against potential shocks, such as IV fluid shortages or global trade disruptions that inflate the cost of essential supplies. By modelling these scenarios, the taskforce can identify vulnerabilities in current funding allocations and operational

dependencies, and be supported to proactively design mitigation strategies. Adopting an agile decision-making approach would ensure that contingency budgets are not only reactive but also strategically aligned with the scale and nature of potential risks.

Embedding scenario planning into Government budget cycles would foster a culture of preparedness across the care sector, empowering care providers to adopt similar approaches in their operational planning. This collective readiness would enhance the sector's ability to maintain service continuity and deliver high-quality care under pressure.

**Recommendation 12:** The Government should establish a dedicated taskforce to embed financial resilience into health and aged care budget planning by developing robust contingency frameworks, incorporating real-time monitoring tools, and employing scenario-based stress testing to anticipate and mitigate risks. This approach should include building flexible funding models and adaptive infrastructure to ensure system-wide responsiveness to crises such as pandemics, climate events, and supply chain disruptions, prioritising equity and continuity of care for vulnerable populations. Embedding these practices into budget cycles will promote proactive preparedness and sustainable service delivery across the care sector.

### **Aligning pricing policy with the real cost of care**

Budget sustainability should start with accurate pricing and funding – which serve as the foundation for effective resource allocation and long-term system resilience. In the health and aged care sectors, this means ensuring that funding models reflect the true cost of delivering high-quality, person-centred care, including workforce wages, rising capital and infrastructure costs, fluctuations in the availability and pricing of clinical supplies, and the inclusion of a diverse range of support services tailored to individual needs. Misaligned pricing can result in underfunding, increase strain on the care workforce, and lead to reduced quality of care outcomes.

Regular reviews of pricing structures, grounded in up-to-date data and informed by meaningful stakeholder engagement, are essential to maintaining financial viability and ensuring that funding keeps pace with macroeconomic trends, demographic changes, and evolving care needs. As the national advisory body for hospital and aged care pricing, the Independent Health and Aged Care Pricing Authority (IHACPA) is well-positioned to lead this effort. By proactively leveraging its existing data assets, IHACPA can strengthen the evidence base underpinning its pricing advice, helping to ensure that funding recommendations more accurately reflect the true cost of service delivery. This would address longstanding concerns within the care sector about the disconnect between pricing advice and the operational realities faced by providers. Specific examples of factors for consideration have been outlined in subsequent sections.

**Recommendation 13** calls for accurate, transparent, and regularly reviewed funding models to sustain high-quality, equitable health and aged care across Australia.

#### *Ongoing monitoring and review*

There is a need for ongoing review of the factors affecting both provider and consumer behaviour when developing pricing advice. For example, factors such as participant co-contributions should inform the pricing advice developed, so that it can collectively drive the desired outcomes of the Support at Home reforms affecting the in-home aged care sector. There is a significant amount of complexity in understanding how older people will be affected

by the transition to Support at Home. CHA has identified that the volume of current arrangements needing to be transitioned to completely different ones remain a significant transition issue impacting the commencement of Support at Home.

Another example of where transparency and clarity should be embedded is in the current review of block funding criteria and associated arrangements for the public hospital sector.

Simplifying IHACPA's pricing and adjustment models is a necessary but delicate task. Guided by the principles of transparency, equity, materiality, and evidence-based design, and implemented through a phased and inclusive process, simplification can improve the usability and coherence of the national pricing system without compromising its core purpose: to fund public hospital services in a way that reflects cost, supports access, and promotes efficiency. As IHACPA embarks on a multi-year program of review, its approach must ensure that simplification enhances, rather than diminishes, the model's ability to serve Australia's diverse hospital system and its communities.

#### *The need for a National Private Price*

Another example is the current pricing arrangements underpinning the private hospital system that are no longer fit for purpose. Current funding is negotiated bilaterally between insurers and providers, with little transparency and no direct link to the cost of care. This outdated approach contributes to inefficiencies, inhibits innovation, and places growing pressure on the financial sustainability of the sector. Government needs to look to adopting a bold, but necessary, reform: a National Private Price — a transparent, evidence-based benchmark for pricing in the private hospital system, modelled on the National Efficient Price used in public hospitals. A National Private Price would provide a foundation for activity-based funding in the private sector, enabling more efficient resource allocation, improving accountability, and supporting value-based care.

A National Private Price would have direct benefits for patients, ensuring continued access to high-quality private healthcare while addressing the financial sustainability of private hospitals. By aligning funding with the actual cost of delivering care, this reform would help maintain the affordability and viability of private healthcare, ensuring patients can continue to benefit from the choice the private health system offers. More information on our work regarding a National Private Price can be found [here](#).

#### *Challenges affecting regional, rural and remote communities*

Care providers incur significantly higher operating costs in regional, rural and remote areas. Limited access to essential health services and infrastructure further restricts options to expand service offerings or achieve efficiencies through economies of scale. For example, the funding model for care providers, known as the Modified Monash Model (MMM), does not accurately reflect the high cost of aged care service provision in mining towns. These towns face significant isolation challenges, located six or more hours by road from metropolitan centres, making essential health services scarce and more costly.

Immediate alternatives are required regarding the categorisation of these communities to ensure older Australians, regardless of where they live, can access safe and high-quality care and providers can continue to operate sustainably. The NDIS has mechanisms to accommodate these outliers, and aged care needs these too. Aged care urgently requires adjustments to the

funding arrangements to ensure older people in regional, rural and remote communities have the same choice, access, and quality of care as others.

**Recommendation 13:** To ensure budget sustainability and system resilience, funding models across health and aged care must accurately reflect the true cost of delivering high-quality, person-centred care, including workforce wages, infrastructure, clinical supplies, and tailored support services. The Independent Health and Aged Care Pricing Authority (IHACPA) should lead ongoing, data-driven reviews of pricing structures, engaging stakeholders to align funding with evolving care needs, macroeconomic trends, and regional cost variations. Additionally, the Government should prioritize establishing a National Private Price to provide transparency, efficiency, and accountability in private hospital funding. Urgent adjustments are also needed to funding models for regional, rural, and remote communities to address their higher operating costs and ensure equitable access and quality of care for all Australians.

### **Investing in the workforce to ensure system stability**

Workforce stability is the cornerstone of a sustainable healthcare system. Achieving this stability requires targeted investment in recruitment, attraction, and retention strategies, alongside regulatory flexibility that enables adaptive staffing models tailored to workforce availability and the specific care needs of diverse communities, as outlined in

#### **Recommendation 14.**

*Funding models must reflect structural workforce constraints*

National pricing and funding mechanisms must evolve to better reflect the structural cost barriers faced by smaller hospitals and Local Health Networks (LHNs), which often operate without the efficiencies of scale available to larger facilities. These barriers include high fixed costs associated with low-volume service delivery, premium labour and incentive costs needed to attract and retain skilled staff, and the additional resource intensity resulting from limited access to diagnostics, allied health, and specialist support. Further compounding these challenges are the requirements to maintain 24/7 service capability regardless of fluctuating demand, rigid workforce regulations that constrain scalability, and the duplication of services across geographically dispersed sites. Addressing these systemic constraints is essential to ensuring equitable access to care and the long-term viability of health services, particularly in regional and remote communities.

As outlined earlier, enabling the care workforce to operate at their full scope of practice is a vital part of achieving workforce stability. Empowering health and aged care professionals, such as nurses, allied health practitioners, and personal care workers, to fully utilise their training and qualifications enhances care efficiency, improves job satisfaction, and supports retention. A stable and optimally utilised workforce reduces reliance on reactive, high-cost staffing solutions and minimises service disruptions, both of which are critical to achieving budgetary resilience. By investing in workforce capability and regulatory reform, the Government can lead the development of a more predictable, efficient, and sustainable care delivery model that underpins long-term financial planning and system stability.

**Recommendation 14:** Government should invest in targeted workforce stability strategies, including flexible staffing models, scope-of-practice reforms, and structural funding adjustments, to support the long-term viability of small and regional health services and ensure a sustainable, high-performing care system.

### **Prioritising prevention and early intervention**

A major barrier to strengthening preventative and early intervention health programs is the dominance of short-term political and budgetary cycles in public policymaking. Evidence-based prevention initiatives often require upfront investment and yield measurable outcomes only over the long term, well beyond electoral and budget reporting periods. This makes it difficult for decision-makers, under pressure to deliver quick wins, to justify sustained investment. Australia's federated system further complicates this, with unclear and overlapping responsibilities across local, state, and federal governments leading to inconsistent approaches and blurred accountability. Institutional and cultural barriers within the bureaucracy also inhibit coordinated action, as interdepartmental mechanisms are frequently under-resourced or lack the authority to drive collaboration. As a result, accountability for prevention is fragmented which undermines the development and implementation of long-term, system-wide strategies. **Recommendation 15** calls for government to invest in long-term, coordinate prevention strategies supported by collaborative commissioning, clear outcome measures, and robust data infrastructure.

#### *Sustained, coherent investment into prevention and early intervention*

There is significant opportunity for Government to address these barriers through prioritisation of sustained, coherent investment into prevention and early intervention programs. This may involve prioritisation of strategic partnerships and an active pursuit of collaborative commissioning as a core component of investment decisions into preventative efforts. Doing so will require addressing previously identified barriers to collaborative commissioning and fostering joint funding arrangements that embeds collaborative commissioning across the care economy. This approach should be guided by a clear, government-led strategy to ensure sustained and coordinated implementation of prevention activities.

To support budgetary resilience and long-term fiscal sustainability, Government could invest in a prevention data and digital infrastructure pilot aimed at addressing structural barriers to effective planning and evaluation. This pilot would establish an integrated data platform that links prevention initiatives with broader care economy datasets, including primary care, community services, and existing government-held indicators of health system performance. By closing gaps in data and evaluation infrastructure, the platform would enable continuous outcome measurement, real-time monitoring, and predictive modelling. It would also trial advanced evaluation frameworks to better quantify the diffuse and long-term benefits of prevention beyond direct financial metrics, supporting more informed and strategic investment decisions. Importantly, this initiative should align with existing wellbeing and health policy frameworks, such as Measuring What Matters<sup>4</sup>, to ensure coherence and maximise impact across portfolios.

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<sup>4</sup> *Measuring What Matters* refers to a framework with five wellbeing themes, including a healthy society, sense of security, sustainable use of resources, demonstrates a cohesive culture, and is prosperous. Accessed at: <https://treasury.gov.au/policy-topics/measuring-what-matters>

### *Measuring and evaluating outcomes*

Despite shared goals of improved population health, there is a need for Government to strategically address the challenges with measuring and valuing prevention outcomes. While there is strong evidence that many prevention programs are cost-effective, such as those targeting chronic disease, avoidable hospitalisations, falls prevention, or early childhood development, the benefits are often diffuse and difficult to quantify in financial terms. Government could leverage expertise of established evaluation bodies, such as the Australian Centre for Evaluation (ACE), to conduct robust impact assessments can provide critical insights to inform decisions about initiating or scaling effective prevention programs. Achieving this requires the development of clear, measurable indicators and embedding them into program design from the outset, ensuring that outcomes can be tracked, compared, and used to inform future investment. A proposed framework for measuring and valuing prevention outcomes is outlined in our submission to the Productivity Commission.

**Recommendation 15:** Government should commit to sustained, whole-of-system investment in prevention and early intervention by embedding collaborative commissioning as a standard feature of program design, addressing structural barriers to joint funding, and strengthening data infrastructure to enable real-time monitoring and outcome evaluation. This investment should be underpinned by clear, measurable indicators and supported by evaluation expertise to ensure prevention outcomes can be systematically tracked, valued, and scaled over time.

### **Embed public-private partnerships in future budget frameworks**

Public-private partnerships (PPPs) remain an underutilised lever for achieving budgetary sustainability in the health system. However, the current strain on public resources often limits capacity for proactive engagement and strategic collaboration. Building trusted relationships between public and private stakeholders is further complicated by differing decision-making cultures and priorities. Several persistent barriers continue to hinder the establishment and success of PPP arrangements, including:

- Challenges in establishing secure, transparent frameworks for data exchange and oversight.
- Difficulties in sourcing financial partners and aligning on procurement processes and expectations.
- Limited understanding and management of public perceptions and expectations around private sector involvement in health services.
- Regulatory delays and legal requirements can render projects unfeasible, particularly given the rapid pace of technological change.

As outlined in **Recommendation 16**, addressing these barriers through targeted policy reform, capacity-building, and clearer governance structures could unlock the potential of PPPs to deliver innovative, cost-effective solutions that support long-term fiscal sustainability and improved health outcomes.

### *Designing sustainable and collaborative PPP models*

To successfully establish and scale PPPs, several key enablers should be prioritised:

- Involving stakeholders from both sectors at the outset to build trust, align expectations, and co-design solutions.
- Gaining deep insights into the community context, service needs, and existing infrastructure to ensure relevance and impact.
- Establishing shared terminology and understanding across public and private stakeholders to bridge cultural and operational differences.

By embedding these enablers into PPP design and implementation, Government can foster more collaborative, resilient, and financially sustainable models of care.

Government could facilitate targeted PPPs to enhance service viability and expand virtual care offerings in smaller public hospitals, leveraging the digital maturity and infrastructure of private hospital partners. These initiatives would contribute to a more integrated and resilient hospital sector, ensuring continuity of high-quality care regardless of geographic or resource constraints.

PPPs could also be strategically deployed to address priority areas within the broader health reform agenda. For example, a pilot PPP focused on addiction and mental health services could build on existing collaborations and explore jointly commissioned, integrated care models funded by both public and private sectors. This pilot would prioritise coordinated care pathways, data sharing, and outcome-based contracting to reduce hospital demand and support recovery in community settings. CHA members, particularly those with experience navigating changes in PPP arrangements where public hospitals have found previous models unsustainable, are well-positioned to participate in and provide feedback to help shape these pilots.

**Recommendation 16:** Government should embed public-private partnerships in future budget frameworks by addressing regulatory and structural barriers, supporting pilot programs in priority areas like virtual care and mental health, and fostering co-designed, outcome-based models that draw on the strengths of both sectors.