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Catholic Health Australia Submission: Response to Productivity Commission's Interim Report on Pillar 4 – Delivering Quality Care Efficiently

Thank you for the opportunity to provide Catholic Health Australia (CHA)'s views on the Interim Report for Pillar 4 – Delivering Quality Care Efficiently. CHA appreciates the work of the 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 critical role of government leadership in driving system-wide reform through targeted investment in digital infrastructure, flexible funding models, and collaborative commissioning. Strong leadership, anchored in a shared vision, is essential to building a resilient, equitable, and future-ready care system.

In response to the Productivity Commission's key information requests, our submission highlights several priorities to advance value-based healthcare in Australia. These include transitioning from activity-based to outcomes-based funding to support integrated, preventative models of care. We believe these reforms are essential to overcoming barriers to economic sustainability and equitable access. A clear outcomes framework is also needed to guide investment decisions and track progress, including the implementation of a National Prevention Investment Framework and Fund with transparent public reporting.

We have long advocated for a systematic shift towards adaptive, principle-based regulation that reduces low-value compliance and supports continuous improvement across the care sector. We are encouraged by the Commission's recognition of the need for regulatory reform and its potential to return more time to care. In line with this, we have consistently called for the establishment of a centralised, independent workforce planning body to lead strategic planning and deliver a harmonised, risk-proportionate approach to workforce regulation across care sectors.

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.

Yours sincerely,

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Catholic Health Australia – Response to Productivity Commission's Interim Report on Pillar 4 – Delivering Quality Care Efficiently

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Catholic Health Australia
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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.

Background

In 2024, the Australian Government asked the Productivity Commission to identify the highest priority reform areas under five pillars of productivity, with the goal of delivering practical and implementable policy ideas across the five pillars by the end of 2025.

This submission responds to the Productivity Commission's Interim Report on *Pillar 4: Delivering quality care more efficiently*. Australia's care economy is undergoing significant transformation, marked by a broader range of service options, innovative care delivery models, and evolving consumer expectations. As demand intensifies and costs rise across key sectors — including health, aged care, disability services, and early childhood education — the government is seeking strategies to enhance care quality while alleviating pressure on public budgets and the workforce.

The Interim Report articulates three key policy reform areas for further exploration:

- Reform of quality and safety regulation to support a more cohesive care economy, with an emphasis on getting these regulatory settings right
- Embed collaborative commissioning to increase the integration of care services, address service gaps, and better tailor care services to local needs
- Development of a National Prevention Investment Framework that recognises the cross-sectoral value of preventive initiatives and explicitly accounts for the time needed for their long-term social and economic benefits to emerge.

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 welcomes the Productivity Commission's focus on addressing the productivity challenge by recognising the value of the care economy and proposing key reforms to close existing gaps. CHA supports efforts to ensure the care economy evolves in step with emerging technologies that have the potential to enhance care quality while operating more efficiently.

CHA believes that Australia's care economy can achieve value-based healthcare if the right strategic enablers are in place. These include:

- Regulatory settings that foster innovation while effectively managing associated risks;
- Collaborative commissioning mechanisms that drive better value and outcomes across sectors; and
- Sustained, meaningful investment in prevention, underpinned by a nationally coordinated framework that supports long-term planning and impact.

Key observations and issues related to delivering care more efficiently, as articulated in our submission include:

1. **Shifting away from activity-based funding towards outcomes-based funding:** There is a need for reform of current funding arrangements to support integrated, outcome-based models of care. This should include multi-tiered resources, alignment and clarity of responsibilities for funders, supported by incentives to share costs, rather than shift them. This may include the next NHRA addendum reconfigure funding flows to reward integrated, outcomes-based performance, ensuring that funding structures incentivises

not only provision of quality treatment, but also sustained focus on prevention, equity, and long-term health outcomes.

2. **Develop a clear outcomes framework to support joint monitoring and reporting for collaborative commissioning and to guide investment into preventative health proposals.** An outcomes framework should reflect a range of indicators meaningful to communities and service users; financial and service delivery targets that align with stakeholder priorities; and fundamentally, supported by incentive structures that reward long-term improvements in health and wellbeing, rather than short-term throughput. Furthermore, outcomes-based measures should be embedded into existing performance and accountability measures to track progress, foster a culture of learning and improvement, acknowledge strengths and limitations of current investment approaches, while providing evidence to support a sustained focus on prevention.
3. **Implementation of National Prevention Investment Framework should be supported by the establishment of a National Prevention Investment Fund.** Implementation progress should be tracked through transparent public reporting, drawing on existing national infrastructure to keep outcomes visible across governments and the community. Indicators should be structured as “lead and lag” measures to show early fidelity/uptake signals while longer-run health and fiscal outcomes mature. Further, the establishment of the National Prevention Investment Fund should include development of assessment guidelines and principles designed in consultation with key sector stakeholders.
4. **Ensuring that the care sector systematically shifts towards adaptive, principle-based regulation that is focused on outcomes, risk, and continuous improvement.** This includes reducing low-value regulatory requirements, streamlining compliance processes, and embedding digital solutions to return time to care. Further, this requires embedding adaptive, risk-proportionate regulation as the core component of a standardised reporting framework to enable dynamic assessment of risk and performance and better reflect the complexity and diversity of care delivery.
5. **Establishing a centralised, independent workforce planning body to lead strategic workforce planning and delivery of key initiatives.** This body should also be tasked with the mandate to ensure that a unified approach to worker registration and regulation across the aged care, NDIS, and veterans’ care sectors should be risk-proportionate, cost-capped, and integrated with existing frameworks to avoid duplication. Importantly, ensuring that a harmonised approach to workforce regulation through standardised registration and screening requirements reflects the realities of a shared care workforce.

Contents

Submission

Section 1: Reform of quality and safety regulation to support a more cohesive care economy

CHA supports the Productivity Commission's recognition of the challenges posed by fragmented and misaligned regulation across the care economy. As care delivery becomes increasingly complex, regulation must evolve to remain fit-for-purpose, balancing risk-proportionate protections with flexibility and responsiveness.

CHA views regulation as serving two essential, complementary functions that are both critical to a high-functioning care system:

1. **Ensuring compliance and safety** by identifying gaps in service delivery or areas where minimum standards are not being met.
2. **Recognising and promoting excellence** by highlighting where services exceed expectations and deliver superior outcomes for consumers.

However, these functions can sometimes be in tension, particularly when regulatory frameworks attempt to fulfil both roles simultaneously. The current Star Ratings system in residential aged care homes illustrates this challenge. While designed to inform consumer choice, its aggregated indicators may misrepresent performance, especially in regional and remote areas where alternatives are limited. A low or middling rating may unintentionally signal poor quality, despite a home meeting all legislative requirements.

To address these issues, CHA has continued to advocate for a systematic shift toward adaptive, principles-based regulation that is focused on outcomes, risk, and continuous improvement. This includes reducing low-value regulatory requirements, streamlining compliance processes, and embedding digital solutions to return time to care. Greater alignment should not mean a rigid, one-size-fits-all approach, but rather a shared foundation of principles, language, and standards that can be tailored to different care contexts.

A nationally coordinated framework with interoperable reporting systems, shared outcome measures, and clear distinctions between compliance thresholds and aspirational quality indicators will help build a more person-centred and integrated care system.

Implementation Plan

The proposed implementation plan to support greater regulatory alignment (Figure 1.3) articulates clear actions to support Draft Recommendation 1.1. For example, the proposed national worker screening clearance and a unified approach to worker registration is a reasonable short-term action and should be aligned with existing reform timelines, such as the proposed introduction of a registration scheme for personal care workers in aged care. To ensure successful implementation, the plan must include embedded monitoring and evaluation functions from the outset. This should involve clearly defined outcome measures for each initiative to enable robust assessment of effectiveness at scale. Further, such a clearance scheme should only be introduced based on strong collaboration with the sector and with clearly articulated, mutual responsibilities for workers and providers — ideally supported with funding to cover costs, including transition costs and upfront implementation costs. Specific implementation considerations have been detailed in a subsequent subsection of our response.

This plan could be further developed and based on findings from evaluations of the aged care reforms. Subsequent sections of the submission outline a need to build on lessons learnt from each of the identified care sectors (i.e. aged care, NDIS, and veteran's care) as well as a need for strategic alignment with broader reform efforts will support coherence across care sectors and

reduce duplication. Importantly, the implementation plan must be supported by consistent training materials, systems, and processes to ensure staff are adequately equipped to deliver regulatory advice under the new framework.

Key recommendations articulated in this section include:

1. **Establishment of a centralised, independent workforce planning body**, similar to the former Health Workforce Australia, as a priority to deliver the suite of actions under Draft Recommendation 1.1.
2. **Adopt a harmonised, risk-proportionate approach to care workforce regulation across aged care, NDIS, and veterans' care sectors through a nationally consistent registration and screening system.** This workforce registration and screening should build on existing frameworks, such as the NDIS Worker Screening, and be recognised across all relevant authorities to support workforce mobility and reduce duplication. It must include transitional pathways, acknowledge prior experience, and integrate non-regulatory supports like training access and workforce planning to enhance capability, sustainability, and reduce administrative burden.
3. **Embedding adaptive, risk-proportionate regulation as the core component of a standardised reporting framework**. This approach would enable dynamic assessment of risk and performance and better reflect the complexity and diversity of care delivery. As part of this, address existing barriers to incorporate technology and shared outcome measures as critical enablers for the implementation of such as standardised reporting framework.
4. **Develop a real-time care economy dashboard to track reform progress to support the implementation of a standardised reporting framework.** Such a tool would not only support public transparency but also enable policymakers, providers, and communities to monitor reform efforts and make data-informed decisions.
5. **Publicly report key quality indicators that would support service improvement and innovation.** Key indicators include: outcomes and effectiveness, safety, person-centred experience and engagement measures, access and equity, efficiency, cost, and productivity, workforce capability and culture, improvement and innovation signals, and upstream determinants and prevention coverage.
6. **Adopt lessons learnt from the aged care sector as part of the implementation of a single care provider accreditation and registration process.** Implementation challenges from the aged care sector offer valuable lessons for any future integrated care provider accreditation and registration scheme.
7. **Ensure that a single regulator across aged care, NDIS and veterans' care services should support rather than complicates, quality and safety outcomes.** This requires a flexible, regulatory framework that is informed by the unique characteristics of each care sector and avoids a one-size-fits-all approach. careful planning is needed to ensure that regulatory systems and processes are designed with long-term interoperability and integration in mind, not only across aged care, NDIS, and veterans' care, but also with the broader health system.
8. **Address existing issues facing the regulatory system of these care sectors prior to integration into a single regulatory system and approach.** This foundational step is critical to designing a regulator that not only streamlines oversight but also supports innovation, responsiveness, and long-term productivity across the broader care economy.
9. **Progress implementation initiatives, including those outlined in the Draft Recommendation, through the following.** Future initiatives should draw on existing reform learnings to avoid duplication and inefficiencies; promote transparency around reform initiatives and their effectiveness; and embed evaluation mechanisms to assess regulatory impact and guide continuous improvement.
10. **Establish clear standards for the development, deployment, and oversight of artificial intelligence technologies in care settings, with a focus on transparency,**

accountability, and consumer protection. Key considerations outlined in our response includes: workforce capability, digital maturity, system interoperability, and a need for strengthened governance and oversight.

Alignment of care worker regulation

Workforce shortages across health, aged care, and disability services are straining service delivery, exacerbated by fragmented planning, underutilised national data, and inconsistent state and territory initiatives. CHA strongly supports Draft Recommendation 1.1 to align care worker regulation. Improving workforce quality, safety, and mobility must be risk-proportionate and integrated with broader planning efforts to avoid unintended consequences, particularly in implementing national registration or screening schemes.

To address these considerations, CHA continues to advocates for the establishment of a centralised, independent workforce planning body, similar to the former Health Workforce Australia, as a priority to deliver the suite of actions under Draft Recommendation 1.1. This body should have oversight across health, aged care, and disability sectors, with a mandate to:

- align care worker regulation and streamline registration processes
- analyse and utilise workforce data to inform evidence-based policy
- coordinate national and jurisdictional workforce strategies to meet current and future care needs.

This body must operate with autonomy, be insulated from political influence, and be governed jointly by Commonwealth, state, and territory health ministers. As part of its work, the current Health Workforce Taskforce should consider this model and assess the strengths and limitations of Health Workforce Australia to inform its design and (re)establishment.

In addition, CHA recommends that in the adoption of a unified approach to worker registration across the aged care, NDIS, and veterans' care sectors, the government should consider the following:

- any registration scheme must be pragmatic, proportionate to risk, and embedded within existing regulatory frameworks to avoid duplication
- the system must include transitional and provisional registration pathways and recognise prior learning and experience, including for international workers
- regulatory costs for both providers and workers must be modelled and capped to avoid exacerbating existing workforce pressures
- a nationally consistent background screening process should be adopted to reduce compliance duplication across the Commonwealth Home Support Program (CHSP), NDIS, Home Care Packages (HCP) Program, and Support at Home
- non-regulatory mechanisms, such as investment in training access, workforce planning infrastructure, and provider-led development pathways, be prioritised alongside or ahead of formal registration.

Information request 1.1

For which care services (across aged care, NDIS and veterans' care and beyond) and performance indicators are there the greatest overlap in quality and safety reporting requirements? What are some examples of duplicative reporting requirements across sectors?

A fragmented regulatory framework across aged care, NDIS, and veterans' programs creates unnecessary duplication and inefficiencies for providers and workers. Many aged care staff work

across multiple government-funded programs, such as CHSP, HCP, Support at Home, NDIS, and Veterans' care, yet face inconsistent requirements for background checks, registration, and training.

A harmonised approach to workforce regulation

CHA strongly supports a harmonised approach to workforce regulation. Standardising registration and screening would improve workforce mobility, reduce administrative burden for providers, whilst reflecting the realities of a shared care workforce.

A key concern is the duplication of background screening. An example would be providers that deliver both CHSP and HCP services that often use the same staff but must maintain separate compliance records for police checks and NDIS worker screenings, requiring additional time, efforts and resources in doing so.

Case study: Addressing cost responsibilities of a national screening check

Under the Aged Care Act (S154-1140), providers must record specific workforce information in the Government Provider Management System (GPMS). This includes screening checks such as police certificates or NDIS Worker Screening Checks, with a new national screening check expected from mid-2026.

There is no clear guidance on who pays for these checks — providers or workers. CHA members report inconsistent practices across the sector, with some providers covering costs and others passing them onto staff. Additional fees may apply when decisions are required during the screening process.

This has the following implications:

- Financial strain on workers, especially casual or part-time staff.
- Compliance risks due to unclear responsibilities.
- Workforce retention challenges if costs deter entry into the sector.
- Transition issues as the new screening system is introduced.

Clear expectations around screening costs are essential for fairness, compliance, and workforce sustainability during aged care reforms. CHA urges the Government to clearly define cost responsibilities in policy and in GPMS guidance and consider subsidies for low-income workers.

Further details on our positions on this issue can be accessed here.

Another example of regulatory duplication in aged care is the requirement for providers to submit and maintain third-party contractor information in the GPMS. CHA and its members have observed that these duplicative reporting obligations often result in contractors being treated as if they were employees. This creates a significant administrative burden, as providers must maintain a comprehensive and continuously updated register of all employees and contractors, regardless of whether the contractor interacts directly with consumers or clients. This raises important questions about the appropriateness of the information being collected, the rationale for its collection, and clarity around who is responsible for gathering and reporting this data.

Concerns about entrenched duplication are further amplified with the upcoming commencement of the new Aged Care Act on 1 November 2025. Under the new framework, providers will be required to report workforce data monthly to Services Australia, while also continuing to submit quarterly staffing data through the Quarterly Financial Report (QFR) to both the Aged Care

Quality and Safety Commission and the Department of Health and Aged Care. Another example is the reporting of workforce turnover rates under Indicator 10 of the Quality Indicator Program. These overlapping reporting streams, each with different formats, timelines, and purposes, compound the administrative load and create confusion around which data is used for regulatory oversight, funding, or quality improvement. Without clearer alignment and differentiation between these reporting requirements, providers face ongoing inefficiencies and uncertainty about how this data contributes to improved care outcomes.

CHA recommends a streamlined, national background screening system, ideally building on the existing NDIS Worker Screening framework and aligned with a National Skills and Capability Framework. This system should be recognised by all relevant authorities, including the Aged Care Quality and Safety Commission and the Department of Health, Disability and Ageing.

Supporting the workforce to meet quality and safety regulations

The current aged care reporting framework fails to adequately acknowledge the role of allied health professionals (AHPs) in delivering safe, high quality care. The exclusion of allied health from direct care minutes (care minutes targets) not only creates a gap in workforce recognition but also undermines interdisciplinary practice, which is an essential component of high-quality aged care. This omission results in additional, fragmented reporting requirements for allied health, which are often duplicative and administratively burdensome. For organisations heavily invested in allied health, this poses a significant risk to the sustainability of a skilled and experienced workforce, especially in the context of ongoing nursing shortages.

Allied health in aged care faces unique challenges due to its cross-sectoral nature and the fragmentation of funding and regulatory models. CHA and its members have identified a persistent misalignment between the roles and responsibilities of AHPs and the compliance and reporting frameworks they are subject to. Many AHPs operate across multiple care settings, yet reporting requirements and systems are not designed to reflect this complexity. While policy should drive quality and safety outcomes, the reality is that new reporting obligations often require extensive system upgrades, new data capture methods, and substantial staff retraining — diverting valuable time and resources away from direct care.

A recent example is the introduction of a Quality Indicator requiring providers to report on the proportion of residents with a recommended allied health service in their care plan who have received at least one instance of that service. While intended to monitor allied health activity, this metric focuses on service occurrence rather than outcomes, reinforcing a low standard of care. It adds administrative burden without delivering meaningful insights or value to the care economy.

Access to high-quality, real-time clinical data is essential for evidence-based practice, benchmarking, and workforce planning. However, the current fragmented approach to allied health reporting has led to confusion and inefficiencies. For instance, capturing metrics such as referral volumes or care plans managed by AHPs often requires software changes and retraining, further straining the workforce and risking disruption to care continuity.

To address these challenges, a strategic shift in regulation to focus on quality and safety outcomes is needed. A regulatory shift should align reporting for allied health contributions, as part of a multidisciplinary team, with actual care delivery. Leveraging existing reporting requirements and metrics, rather than creating parallel systems in this shift is key, as it would reduce administrative burden and support a more cohesive, interdisciplinary model of care. Ensuring that indicators are relevant, feasible, and supported by appropriate infrastructure and training will allow reporting to enhance, rather than hinder, care delivery and workforce sustainability.

Information request 1.1 (cont.)

What should a standardised reporting framework for providers look like? Are there examples of cross-sectoral standardised reporting frameworks that have reduced the reporting burden on providers?

The care economy has a valuable opportunity to adopt risk-based, adaptive regulation, moving beyond traditional frameworks that are often binary and static, focused solely on compliance with minimum standards. Instead, regulation should enable dynamic assessment of risk and performance, better reflecting the complexity and diversity of care delivery. 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.

Some examples of cross-sectoral standardised reporting frameworks include:

- Australia's Standard Business Reporting: a standard approach to online or digital record-keeping that was introduced by government in 2010 to simplify business reporting obligations, allowing businesses to lodge multiple statutory reports straight from accounting software to different agencies via one set of definitions.
- Australia's Sustainability Reporting Standards: finalised in September 2024, these standards align with global International Financial Reporting Standards (IFRS) frameworks, providing sector-neutral and consistent disclosure rules that help reduce complexity for entities operating across boarders.
- Australia's Emission Reporting Framework: released in 2025, this framework sets the reporting boundary and emissions calculation methods centrally, resulting in agencies no longer needing to determine their own boundaries or calculation methods, reducing the burden and enhancing comparability across entities.
- Consumer Data Right: a framework governed by legislation and technical data standards that apply across sectors (e.g. banking, energy). Providers adhere to a common data-sharing protocol, ensuring secure, structured data interchange, simplifying compliance across participating stores.
- Singapore's "MyInfo": a cross-government data service that prefills forms for people and businesses (with consent) across agencies and participating private services, removing repeated document uploads and cutting errors/time.
- Norway's "Altinn": a joint reporting channel used by tax, statistics and registries so businesses submit once through a common platform; Altinn underpins Norway's adoption of the once-only principle.
- Canada's Business Number and BizPal: a Business Number is a single business identifier reused across multiple federal/provincial programs to support a tell-us-once model, explicitly designed to decrease administrative burden and reduce duplication across programs. BizPaL aggregates licences/permits across all three government levels, giving businesses a single, standardised view of obligations and reducing paperwork search/duplication.

The key similarities between these different reporting frameworks include:

- common data standards and taxonomies, so the same payload satisfies multiple agencies
- single interfaces that route to many regulators
- unique identifiers to join data and avoid re-keying
- one-only data reuse backed by governance and privacy controls.

Information request 1.1 (cont.)

How could technology be used to support a standardised reporting framework?

Technology should be recognised as a critical enabler in implementing a standardised reporting framework across the care economy. To realise its full potential, existing barriers, such as inconsistent data-sharing regulations, incompatible safety standards, and varying interpretations of scope-of-practice rules, must be addressed through coordinated reform.

A standardised framework should integrate shared outcome measures with targeted technological solutions to accelerate digital adoption and improve data quality. One example is the Australian Digital Health Capability Framework, which outlines essential digital competencies for the health workforce across four domains: the digital workplace, digital professionalism, data and informatics, and digital transformation. Embedding such frameworks into reporting systems can help ensure consistency, support workforce readiness, and enable more responsive, data-driven care.

A practical option to support transparency and accountability is the development of a real-time implementation dashboard. This dashboard could track progress against agreed indicators within the standardised reporting framework, offering visibility into system performance and reform outcomes. A useful precedent is the Organisation for Economic Co-operation and Development's (OECD's) Climate Action Dashboard, which monitors key indicators of climate and adaptation efforts to assess progress toward shared global objectives. Another example is HumanAbility's interactive Data Dashboard which provides real-time insights into each workforce as part of the care economy.

To that extent, a care economy dashboard could include key indicators to track reform progress such as:

- compliance with minimum safety standards
- performance against aspirational quality benchmarks
- workforce capability and digital readiness
- consumer experience and outcomes
- equity of access across geographic regions.

Such a tool would not only support public transparency but also enable policymakers, providers, and communities to monitor reform efforts and make data-informed decisions.

However, it is important to recognise the varying levels of digital maturity across health services in Australia. These differences may unintentionally act as a barrier to digital capability uplift, particularly during the initial implementation and long-term sustainability of the reporting framework. Any digital solution must therefore be scalable, flexible, and supported by targeted investment in infrastructure and workforce capability to ensure equitable participation across all care settings.

To address this, the Government could incorporate a digital maturity indicator within the reporting framework itself. This could draw on existing state and territory models, such as the Department of Health's Digital Health Maturity Model in Victoria, which defines digital maturity as a key enabler of strengthened governance and stewardship across the health system. Embedding such

an indicator would allow for tailored support and investment, ensuring that all services, regardless of their starting point, can participate meaningfully in the digital transformation of care.

Information request 1.1 (cont.)

What quality information should be publicly reported to support service improvement and innovation?

Public reporting of key quality information is vital to driving service improvement, innovation, and consumer trust. To support meaningful system-wide progress, CHA supports the recommendation for a standardised reporting framework that prioritises consistency, transparency, and efficiency. Existing data collected across various regulatory bodies should be critically assessed and justified, with a focus on the principle of "collect once, report once, and use often." This approach reduces duplication, streamlines provider obligations, and ensures that data is leveraged effectively to inform quality improvement across the care economy.

To support service improvement and innovation, CHA recommends the following quality information should be publicly reported:

Outcomes and effectiveness

Public reporting should prioritise outcomes that reflect whether services are achieving their intended goals. This means focusing on tangible measures such as readmissions, functional gains, completion rates, or employment outcomes, depending on the sector. In healthcare, indicators might include adherence to best-practice guidelines and avoidable complications, while in education it could be student achievement or retention. In aged care, it might include a focus on adherence to quality standards or minimising unplanned hospital admissions. Reporting these outcomes enables providers and policymakers to identify what works, what doesn't, and where innovations are needed. International frameworks such as the Australian Health Performance Framework (AHPF) and the OECD's Health Care Quality Indicators both emphasise outcomes as the cornerstone of quality measurement because they directly link service delivery to community impact.

Safety

Safety information is equally critical to support improvement. This includes reporting on sentinel events, adverse outcomes such as healthcare-associated infections, and medication errors, alongside accreditation results against national safety standards. Publishing this information helps shine a light on system vulnerabilities and creates opportunities for shared learning. For example, Australia's National Safety and Quality Health Service Standards (NSQHS) are underpinned by the principle that transparent reporting of safety failures not only protects consumers but also fosters innovation by encouraging the adoption of new practices that reduce risks.

Person-centred experience and engagement

To support innovation, service users' voices must be visible in reporting. This involves the use of standardised Patient Reported Experience Measures (PREMs) and Patient Reported Outcome Measures (PROMs), as well as complaints data and information on how feedback has been acted upon. Beyond simple satisfaction surveys, these measures give insights into lived experiences and unmet needs, highlighting areas ripe for service redesign. Reporting should also cover the extent of consumer involvement in co-design activities, showing where service improvements have been shaped by those who use them. International evidence suggests that transparent reporting of experience measures drives providers to innovate in ways that make services more accessible, responsive, and humane.

Access and equity

Improvement also depends on knowing who is, and isn't, accessing services. Reporting should therefore cover timeliness, availability, and geographic distribution of services, along with measures of digital accessibility where relevant. Crucially, these data must be disaggregated by population groups, such as Aboriginal and Torres Strait Islander peoples, people with disabilities, and those in rural and remote areas, so inequities can be identified and addressed. The AHPF and the Productivity Commission's Report on Government Services (RoGS) both highlight equity as a central quality domain, recognising that innovation is often needed to overcome structural barriers that prevent certain groups from benefitting from public services.

Efficiency, cost, and productivity

Efficiency data provides another essential dimension for improvement. This includes reporting on unit costs, length of stay or cycle times, staff utilisation, and no-show rates. Publishing this information enables comparisons between providers and highlights innovations that deliver better value for money. In Australia, the RoGS framework balances efficiency alongside equity and effectiveness, underscoring that high-quality services should not only be fair and effective but also sustainable. By making these data public, governments can create an environment where providers are encouraged to trial new models of care, technology, or processes that improve productivity without compromising outcomes.

Workforce capability and culture

No service can improve without a capable and engaged workforce, so reporting should include measures such as staffing levels, skill mix, turnover, training rates, and the extent to which staff are empowered to engage in quality improvement. Workforce surveys on culture, psychological safety, and leadership effectiveness can also provide important signals about an organisation's ability to sustain innovation.

Improvement and innovation signals

Beyond outcomes and processes, reporting should also make visible the quality improvement efforts themselves. This includes publishing information about current improvement projects, the methodologies used, and whether initiatives were adopted, adapted, or abandoned. Participation in external benchmarking, audits, and registries should also be reported, as these activities expose providers to external learning and innovation. The United Kingdom's National Health Service (NHS) "Quality Accounts" model provides a strong example: providers publish not only their performance data but also a narrative on improvement priorities and progress, which creates a transparent cycle of learning and innovation.

Determinants and prevention

Finally, quality reporting should extend beyond the immediate service to cover upstream determinants of demand and outcomes. For example, health services might report on preventive coverage and population-level risk factors, while employment services might publish data on socioeconomic conditions affecting jobseekers. The AHPF explicitly integrates determinants of health with system performance, recognising that innovation often comes from tackling the root causes of poor outcomes rather than treating the symptoms alone. Making this information public encourages collaboration across sectors and supports systemic innovation.

Potential pilot programs

To support the development of quality indicators, CHA proposes the following pilots to improve safety and quality regulation:

- **Cross-jurisdictional regulatory alignment pilot:** This pilot would involve providers operating in multiple states trialling a harmonised set of quality and safety reporting requirements developed jointly by federal and state regulators. The aim would be to assess whether adopting a common compliance framework reduces administrative burden, improves operational efficiency, and allows providers to redirect resources toward patient care. As many CHA members deliver services across a range of care settings (i.e. public and private hospitals, aged care, community care, and social outreach), there is an opportunity for effective trialling of whether the developed set of requirements would work across multiple care settings.
- **Common quality indicators and shared outcomes framework trial:** This pilot would include the development and trial of a common set of quality indicators and shared outcomes framework across care settings. Focusing on a shared patient group, such as those with chronic heart failure, this pilot would test whether consistent outcome measures improve collaboration, data consistency, and performance benchmarking across hospital, aged care, and community care sectors.

Alignment of the approach taken to care provider accreditation, registration and audits

As articulated in Box 1.2, aged care, NDIS and veteran's care sectors are known to share many similarities in areas of legislation, service provision, workforce, and to some extent, care recipient profiles. With more than 42% of all aged care providers also being a registered NDIS provider, with these providers typically reflecting a larger proportion of services delivered, there is significant opportunity for an effective, nationally-coordinated approach to care provider accreditation, registration and audits. This section provides examples of lessons learned the aged care sector, as a glimpse of where efficiency gains could be achieved when designing the approach taken to care provider accreditation, registration and audits.

Care provider accreditation and registration

From 1 November 2025, all aged care providers must be registered with the Aged Care Quality and Safety Commission (ACQSC) to deliver government-funded services under the new Aged Care Act. This marks the beginning of a universal provider registration pathway, with ACQSC responsible for overseeing registration and renewal. CHA and its members broadly support the intent and conditions of this registration process. However, several implementation challenges offer valuable lessons for any future integrated care provider accreditation and registration scheme:

- **Applicable scope and clarity:** The Act uses terms like "aged care workers" to encompass the entire workforce. When applied to registration conditions, this broad language risks overreach and impractical compliance expectations. Future schemes must include clear guardrails to ensure provisions appropriately recognises the diversity of care contexts and settings.
- **Guiding principles to promote flexibility and innovation:** Rigid regulatory mandates often fail to accommodate local contexts. Embedding guiding principles, rather than one-size-fits-all rules, can empower providers to innovate and deliver evidence-informed care

tailored to community needs. An example of where guiding principles could be useful has been provided in the case study on meal obligations for in-home aged care providers.

- **Detailed implementation roadmap with embedded codesign:** Large-scale reform requires a detailed roadmap with early and ongoing co-design involving providers and stakeholders. This should include: continuous monitoring and evaluation; investment in capacity-building; and supporting mechanisms, such as tailored incentives to address barriers to participation, to ensure providers can engage meaningfully and sustainably with the scheme.

Case study: Meal obligation for in-home aged care

Section 148-20 of the Aged Care Rules outlines obligations for providers delivering Commonwealth-funded meals to older people at home and during community respite. These rules aim to ensure meals are nutritious, appetising, and responsive to individual preferences, with oversight by Accredited Practising Dietitians (APDs).

While well-intentioned, applying uniform regulatory requirements across diverse care settings, particularly home and community care, creates operational and financial strain, resulting in the following implications on providers:

- **Efficiency:** Unlike residential care, home settings require individualised meal preparation. Providers must assess kitchen suitability, bring equipment, and often hire subcontractors to meet standards.
- **Effectiveness:** APD assessments may conflict with consumer choice. If clients decline assessments, providers face compliance uncertainty. Offering rotating menus tailored to individual preferences is logistically difficult.
- **Cost:** APD oversight across varied menus and settings can cost thousands annually. Remote assessments are possible but hard to scale sustainably.

CHA continues to advocate for a risk-proportionate, adaptive and principles-based regulation of providers to enable greater focus on outcomes of increased nutritional standards, dignity and consumer choice. In practice, this would enable providers to adapt meal services to local contexts and client needs, leverage flexible models of care, and demonstrate innovation in menu design and delivery.

Further details on our positions on this issue can be accessed here.

Consistency and clarity of audit processes

The requirement to report care minutes in the Quarterly Financial Reports (QFR), alongside other indicators such as labour costs and nutrition, illustrates regulatory duplication in aged care. These reports rely on data from multiple systems — rosters, payroll, invoicing — yet the relevance of this data to safety and quality outcomes remains unclear. Minor deviations, such as late invoices, can trigger compliance reviews involving extensive documentation and regulator engagement, despite the presence of an independent audit process. CHA members report that reassessments can consume up to 65 hours of staff time, often with minimal feedback.

Further duplication arises from inconsistent audit practices across aged care settings — residential, home, community, and transitional care — with differing interpretations and regulatory advice. This example highlights the urgent need for a consistent, streamlined approach to quality and safety regulation that reduces administrative burden and clarifies how reported data

contributes to improved care outcomes. For any given data request, there must be a clear rationale for its collection, a clear benefit to quality or safety, and regular reviews to ensure the rationale is being delivered upon.

CHA acknowledges the need for regulation that ensures safety and quality. However, data collection without clear benefits increases costs and cybersecurity risks while diverting resources from the delivery of care.

Information request 1.2

What are the costs, benefits and risks of a single quality and safety regulator across aged care, NDIS and veterans' care services?

Establishing a single quality and safety regulator across aged care, NDIS, and veterans' care offers clear benefits, particularly in enhancing consistency in regulatory advice, reducing duplication, and enabling cross-sector knowledge sharing. A unified regulator would have visibility across all care sectors, allowing for better identification of gaps and opportunities to adapt successful regulatory approaches from one sector to another.

However, the costs of such a transition are significant. These include substantial upfront investment in designing and implementing a fit-for-purpose regulatory framework, especially as aged care undergoes major reform under a new rights-based legislative model. Staff training would also be essential, given that current regulators typically specialise in one sector and may lack familiarity with others.

While there are similarities across aged care, NDIS, and veterans' care, differences, particularly in funding models and service delivery, must be carefully considered to ensure that a single regulator supports, rather than complicates, quality and safety outcomes. A uniform regulatory approach risks overlooking critical nuances that underpin each system's design and purpose. For instance, the NDIS is structured to support individuals under 65 years of age, whereas residential aged care is increasingly focused on those over 65. This divergence in target populations reflects broader differences in policy intent, service pathways, and funding arrangements. Without careful consideration, a single regulator could inadvertently introduce complexity or misalignment, rather than streamlining oversight. This example highlights the need for a tailored, responsive regulatory framework that is informed by the unique characteristics of each care sector and avoids a blanket approach.

Broader systematic risks must also be addressed, these may include the following:

- System interoperability: Existing reporting systems are not aligned across sectors, and without integrated infrastructure, a single regulator cannot function effectively.
- Entrenched duplication: Without a comprehensive mapping of current regulatory overlaps, there is a risk that duplication persists under a unified model.
- Workforce planning: A lack of coordinated, strategic workforce development across sectors could lead to inconsistent implementation and undermine the effectiveness of a consolidated regulator.

A well-planned transition must include a thorough review of existing policies, ensuring that sector-specific needs are preserved and strengthened under any new regulatory model.

Information request 1.2 (cont.)

To what extent would a single regulator produce a more coordinated, consistent and efficient system, especially if regulation was based on a single set of practice and quality standards and a single provider registration and audit system?

A single quality and safety regulator across aged care, NDIS, and veterans' care has the potential to deliver a more coordinated, consistent, and efficient system, particularly if built on a

shared set of practice and quality standards, and a unified provider registration and audit framework. This approach could reduce duplication, streamline compliance, and enable better cross-sector learning and oversight.

However, to realise these benefits, several enablers must be in place. Differences in funding models and service expectations across sectors could undermine consistency. Clear governance structures, well-defined roles and responsibilities, and transparent data and evidence requirements are essential to support effective regulatory decision-making and continuous improvement.

Implementing a single set of standards would be challenging but necessary. Equity in how these standards are rollout must be considered, especially given existing workforce pressures and resource constraints for providers in thin markets. A national strategic workforce body, such as Health Workforce Australia, would be critical to translating these standards into workforce planning and development.

Lessons from the implementation of the Strengthened Quality Standards in aged care should inform the design of shared standards. This includes sector consultation, clear implementation guidelines, and testing with providers to ensure relevance and feasibility.

Similarly, a unified provider registration and audit system could be feasible but requires thorough mapping of existing systems across sectors to identify commonalities and effective practices. Iterative development, sector consultation, and streamlined evidence requirements are essential to avoid entrenching regulatory burden. Transparency in how lessons learned, particularly from aged care reforms, are applied will be key to building trust in the new framework. Further, existing work and recommendations from the NDIS Review (2022) and the Royal Commission (2019) should be addressed prior to adopting a unified system.

While there may a short to medium-term opportunity to align regulatory approaches across aged care, NDIS, and veterans' care, this must be viewed within the broader strategic context of planning for an integrated care economy. A single regulator, supported by a unified set of practice and quality standards and a consolidated provider registration and audit system, could deliver greater consistency, coordination, and efficiency across these sectors.

However, to avoid entrenching existing siloes, careful planning over a reasonable timeframe is needed to ensure that regulatory systems and processes are designed with long-term interoperability and integration in mind, not only across aged care, NDIS, and veterans' care, but also with the broader health system. This includes clear governance structures, defined roles and responsibilities, and safeguards to support cross-sector collaboration.

Strategic investment in infrastructure, workforce planning, and sector engagement will be essential to ensure that the care economy evolves as a unified system, rather than a collection of disconnected services. This approach will help mitigate inefficiencies and support the delivery of high-quality, person-centred care across all settings.

Information request 1.2 (cont.)

How might a single regulator be unable to accommodate differences in services and service users across sectors? What could be the consequences?

To ensure that a single regulator can effectively address existing inefficiencies and unlock productivity gains across aged care, NDIS, and veterans' care, there must first be alignment in the identification and understanding of current regulatory barriers and opportunities. A coordinated assessment of each sector's regulatory systems is essential to avoid replicating inconsistencies or entrenched burdens in a consolidated model.

A single regulator must be sufficiently resourced and capable of demonstrating a nuanced understanding of the distinct services and service users across these sectors. This requires consistent, fit-for-purpose training materials, systems, and processes to support staff in delivering accurate and responsive regulatory advice. Further details and examples are provided in our response to Information Request 1.3.

CHA and its members have consistently highlighted opportunities to improve aged care regulation, particularly the need for clearer guidance, operational detail, and flexibility to reflect the realities of service delivery, especially in regional and remote areas. Inconsistent advice and fragmented communication continue to pose operational challenges and increase administrative burden.

Before integration, these existing issues must be addressed through a comprehensive mapping of regulatory functions, supported by sector engagement and infrastructure investment. This foundational step is critical to designing a regulator that not only streamlines oversight but also supports innovation, responsiveness, and long-term productivity across the broader care economy.

Alignment of the broader regulatory landscape

It is widely known that regulatory burden remains one of the most significant constraints on productivity in the care economy. To address this, alignment across the broader regulatory landscape must be informed by lessons learnt from previous reform efforts and a commitment to evidence-informed practice. For example, the interim report references the establishment of the Care and Support Reform Unit within the Department of Health, following the conclusion of the Care and Support Economy Taskforce in June 2024 (Box 1.1). This unit was tasked with supporting, tracking, and advising on reform alignment across care sectors. However, there is limited visibility into its outcomes or impact, which could otherwise provide valuable insights for future regulatory reform.

To ensure meaningful progress on proposed reform efforts, such as those articulated in Draft Recommendation 1.1, and summarised in Figure 1.3, future efforts should:

- Draw on existing reform learnings to avoid duplication and inefficiencies.
- Promote transparency around reform initiatives and their effectiveness.
- Embed evaluation mechanisms to assess regulatory impact and guide continuous improvement.

By prioritising streamlined, coordinated regulation, informed by real-world experience, the care economy can better support providers, reduce administrative overhead, and unlock productivity gains.

A consistent regulatory approach to Artificial Intelligence (AI)

While there are clear commonalities between certain care sectors, as outlined in previous sections of this submission, there should be broader considerations around what is needed to establish and sustain a consistent regulatory approach to AI (Figure 1.3).

The adoption of AI in the care economy is not without its challenges. It requires a robust and consistent regulatory framework to ensure safety, ethical use, and equitable access. A future-oriented regulatory approach must establish clear standards for the development, deployment, and oversight of AI technologies in care settings, with a focus on transparency, accountability, and consumer protection.

Key considerations include:

- Workforce capability: Significant investment in training and education is needed to equip the care workforce with the skills to effectively use AI tools. This includes both technical competencies and an understanding of ethical and clinical implications.
- Digital maturity: Providers across the care economy vary widely in their digital readiness. A consistent regulatory approach must account for these differences and support scalable infrastructure development, including secure data systems and computing capacity.
- System interoperability: AI implementation must be supported by interoperable systems that enable safe data sharing and integration across care sectors and with the broader health system.
- Governance and oversight: Clear governance structures are essential to guide AI use, monitor risks, and ensure continuous improvement. This includes mechanisms for evaluating AI performance, addressing unintended consequences, and updating standards as technologies evolve.

By embedding these considerations into a unified regulatory framework, governments and regulators can ensure that AI enhances care delivery while safeguarding quality, safety, and equity across the care economy. Further information on our positions regarding a consistent regulatory approach to AI is available in our submission to the Safe and Responsible Artificial Intelligence in Health Care — Legislation and Regulation Review.

Potential pilot

To address persistent challenges in navigating complex and fragmented regulatory frameworks, this pilot explores the development of an *agentic intelligence platform* designed to provide consistent, adaptive guidance to providers. The platform leverages a shared set of standards, principles, and regulatory definitions, enriched with case studies and worked examples. Further, the platform could be trained and/or designed as an adaptive learning system that automatically updates and learns as further insights are collected by auditors and providers alike. This approach enables technology to serve as a reliable source of truth, supporting auditors in delivering consistent and reasonable assessments, ultimately mitigating issues of inconsistency and regulatory fragmentation.

However, the success of this pilot hinges on the creation of a comprehensive and well-calibrated framework. It must account for regulatory nuances and be developed through a robust co-design process with stakeholders. Subject matter expertise would be required in the development of this platform. This ensures the platform is fit-for-purpose and avoids reinforcing existing siloes or deepening technological inequities, particularly those affecting communities with limited access to digital infrastructure.

Importantly, the platform should be developed iteratively and incorporate principles of 'sandboxing' so that both developers and users can experiment and learn alongside the agent. This enables genuine participatory processes of codesign, in which user feedback directly informs implementation outcomes.

By prioritising inclusivity, transparency, and adaptability, the pilot aims to demonstrate how intelligent systems can enhance regulatory clarity while promoting equity and trust across diverse sectors.

Information request 1.3

What are the potential benefits and costs of aligning regulatory requirements across aged care and NDIS services for the development of behaviour support plans?

What is the scope to align regulatory requirements for the use and authorisation of restrictive practices within NDIS services and across aged care and NDIS services?

Building on earlier commentary regarding sector-specific nuances, particularly between aged care and the NDIS, the alignment of regulatory requirements for behaviour support planning presents both opportunities and significant challenges. While consistency may improve administrative efficiency and cross-sector collaboration, it must be approached with caution and nuance, especially in relation to restrictive practices.

At the heart of this issue lies the complexity of determining what constitutes a restrictive practice. Definitions vary not only across jurisdictions but also between care contexts, influenced by differing models of care, professional scopes of practice, and individual rights frameworks. In the NDIS, restrictive practices are tightly regulated under a rights-based framework, with a strong emphasis on behaviour support planning and oversight. In aged care, however, the application of restrictive practices often intersects with clinical decision-making, duty of care, and risk management, making a uniform regulatory approach difficult to implement without unintended consequences.

A high-level, standardised regulatory framework risks oversimplifying these complexities. Without careful consideration, such an approach may inadvertently increase the use of restrictive practices, particularly in aged care settings where behavioural support planning is less embedded in practice. This could undermine broader policy reforms aimed at promoting person-centred care, autonomy, and dignity, principles that are foundational to both the NDIS and aged care reforms.

To ensure regulatory alignment does not hinder progress, several critical factors must be addressed:

- Workforce capability and training: Staff across aged care, disability services, and veterans' care must be equipped with the appropriate skills to develop and implement behaviour support plans. This requires targeted training and a shared understanding of behavioural frameworks, therapeutic approaches, and human rights principles.
- Scope of practice and sector philosophies: Each sector operates within distinct professional boundaries and care philosophies. Regulatory alignment must respect these differences while fostering collaboration and consistency in care delivery.
- Regulatory flexibility: A rigid framework may constrain innovation and responsiveness. Instead, regulation should support tailored approaches that reflect the lived experiences and evolving needs of individuals, while maintaining shared standards across sectors. This is particularly the case when considering the volume and type of providers that are currently registered, and whether a single registration system may exacerbate existing barriers.
- Workforce sustainability: Disparities in wage compensation between NDIS and aged care staff pose a significant risk to workforce retention and attraction. Regulatory reform must be accompanied by investment in the aged care workforce to ensure alignment efforts do not destabilise the sector.

Embedding principles of Value-Based Health Care (VBHC) into regulatory reform offers a strategic pathway forward. VBHC prioritises outcomes that matter most to individuals, supports quality improvement, and promotes efficient resource use. By aligning regulatory efforts with VBHC, policymakers can ensure reforms are person-centred, equitable, and sustainable.

Ultimately, while regulatory alignment may offer benefits, it must not come at the expense of sector-specific responsiveness or individual rights. Rather than mandating a single regulatory framework across aged care and NDIS, efforts should instead focus on implementing the recommendations of the NDIS Review and the Disability Royal Commission. These would provide a well-considered roadmap for reform that is grounded in lived experience, evidence, and a commitment to human rights, ensuring that behaviour support planning and the regulation of restrictive practices remain effective, ethical, and person-centred across all care settings.

Section 2: Embed collaborative commissioning to increase the integration of care services

CHA strongly supports Draft Recommendation 2.1 and the integration of collaborative commissioning into policy frameworks as a key lever for driving productivity gains and economic resilience across the care economy. Collaborative commissioning enables more person-centred, coordinated care by reducing duplication, addressing service gaps, and improving continuity for individuals. It also strengthens local responsiveness, fosters shared accountability for outcomes and spending, and creates a foundation for innovation and continuous improvement.

This section outlines key considerations for enabling collaborative commissioning, focusing on: (1) design and implementation of new joint governance arrangements; (2) reform of funding structures to support integrated, outcome-driven care models; and (3) other barriers to collaborative commissioning.

Key recommendations articulated in this section of our submission includes:

1. **Establish new joint governance arrangements to support collaborative commissioning.** In particular these arrangements should include: strengthened requirements for a formal joint collaborative commissioning committee; work is underpinned by formal agreements; and be aligned with relevant performance and accountability frameworks.
2. **Develop data-sharing arrangements to address existing barriers to collaborative commissioning.** The development of data-sharing arrangements should be positioned as a core component of the joint governance framework and should be guided by key design considerations, as outlined in our submission, to enhance the ability to pool and analyse data across sectors to identify needs, track outcomes, and support continuous improvement.
3. **Develop a clear outcomes framework to support joint monitoring and reporting, and to build a shared vision for collaborative commissioning.** Such a framework should reflect: shared, person-centred outcomes that are meaningful to communities and service users; financial and service delivery targets that align with stakeholder priorities; and supported by incentive structures that reward long-term improvements in health and wellbeing, rather than short-term throughput.
4. **Ensure that partnerships between LHNs and PHNs with ACCHOs and other organisations are not limited to ad hoc consultation, but grounded in formal, accountable arrangements that reflect the principles of the National Agreement on Closing the Gap**. These partnerships should enable shared decision-making, stronger support for the community-controlled sector, systemic transformation to ensure cultural safety, and shared access to regional data.
5. **Key resourcing considerations for joint governance requirements should include dedicated personnel, capacity-building initiatives, fit-for-purpose infrastructure, and dedicated funding for embedded evaluation.** These resources are essential to ensure that all partners can engage meaningfully in joint decision-making and governance processes. Specific funding strategies for collaboratively commissioned services should also be formalised through intergovernmental agreements or memoranda of understanding, which clarify roles, contributions, and risk-sharing mechanisms.
6. **Ensure that the types of funding considered in-scope for pooling are collectively determined by participating stakeholders, guided by a shared understanding of priorities, service needs, and opportunities to reduce duplication.** These discussions should aim to identify areas where existing expenditure can be redirected from administrative overheads to frontline service delivery, thereby enhancing the quality and timeliness of care.

7. **Development of a funding adjustment for collaborative commissioning should involve a once-off grant scheme.** This scheme would be designed to pilot the feasibility of pooled funding mechanisms and joint governance arrangements. An opt-in system would encourage genuine, values-aligned partnerships, and mitigate the risk of reinforcing siloes within the care economy.
8. **Provide support to address costs of participating in collaborative commissioning.** There are a range of upfront investment costs and longer-term costs to sustain programs. Targeted capability funding for smaller providers should therefore be built into commissioning budgets to mitigate the risk of undermining the equity goals of collaborative commissioning.
9. **Address cultural and organisational barriers to collaborative commissioning through an investment in structures and processes that deliberately foster trust, mutual respect, and shared purpose across sectors.** This includes the establishment of regional commissioning collaboratives or alliances; ensuring that all stakeholders, particularly community-based organisations and Aboriginal Community Controlled Health Organisations (ACCHOs), have an equal say in planning and decision-making; and recognition of a need for flexible partnership models that reflect the unique needs, capacities, and cultural considerations of each region.
10. **Support workforce capacity and leadership to develop skilled leaders to undertake effective collaborative commissioning.** This should include the investment in a national leadership development strategy for collaborative commissioning, targeting emerging and existing leaders across health, aged care, disability, and social services.
11. **Design and implement a policy framework for collaborative commissioning.** This policy framework should set a clear direction for collaborative commissioning, articulating shared goals and indicators of success that is relevant to the jurisdiction.
12. **Develop a comprehensive evaluation to ensure accountability and continuous improvement for collaborative commissioning**. This plan should include agreed-upon indicators that reflect person-centred outcomes aligned with the goals of integrated care, such as improved patient experience, reduced avoidable hospitalisations, enhanced capability-building, and strengthened continuity of care.
13. **Address legacy structures that that limit flexibility in how funding is used, what services can be commissioned, or which outcomes are measured.** Specific initiatives could include mapping of existing programs and their funding streams; developing strategies for change to adapt or transition these legacy programs; and embed policy levers that support integrated service delivery.
14. **Align funding to outcomes across care sectors to further integrate and expand place-based approaches to care.** Addressing structural fragmentation between funding sources is essential for the success of collaborative commissioning. This requires use of funding mechanisms such as bundled payments, shared savings models, and pooled budgets, whilst supporting care professionals to work at their full scope of practice.

Designing new joint governance arrangements

Information request 2.1

What additional factors to establish a consistent joint governance framework should be considered?

Formalisation of a joint commissioning authority

CHA strongly supports the establishment of new joint governance arrangements to support collaborative commissioning. The draft recommendation outlines elements of a joint commissioning framework, involving formal requirements for LHNs and PHNs to work together, and in partnership with ACCHOs and other organisations. In particular, CHA is supportive of the need for strengthened requirements for a formal joint collaborative commissioning committee.

This committee should comprise of representatives from all contributing funding authorities, service providers, and consumer groups. This body would be responsible for planning services, allocating funding based on shared priorities, undertaking quality improvement initiatives, and monitoring outcomes over the long-term. Evidence from NSW's Collaborative Commissioning shows that formal LDH-PHN partnerships with clear local mandates can reduce hospital demand and coordinate patient-centred care, which is an implementation signal for how joint committees can operate in practice. In addition, the NHRA Mid-term Review recommends moving toward a single, collaborative, whole-of-system agreement, reinforcing the need to embed joint governance and shared funding rules in the next NHRA. It explicitly recommends that the next addendum should reinforce "a shared national commitment and program of action on long-term health reform areas", including collaborative commissioning, prevention, data-sharing, and innovative funding models. This creates a timely window to formalise joint approaches and align funding with improved health outcomes.

Crucially, the work of this committee, and collaborative commissioning initiatives generally, would need to be underpinned by formal agreements, such as intergovernmental accords or memoranda of understanding, that clarify roles, contributions, and risk-sharing arrangements. These agreements would establish a stable foundation for sustained stakeholder commitment, helping to safeguard momentum against disruptions such as staff turnover or other unforeseen changes. To strengthen cultural safety and shared decision-making with ACCHOs, governance instruments should explicitly align to the National Agreement on Closing the Gap Priority Reforms (especially formal partnerships and shared decision-making) with tracked targets and outcomes. Joint committees should also align with the Commonwealth's PHN Performance and Quality Framework so that planning, commissioning, and reporting are consistent with national outcome domains (e.g. coordinated care, access, capable organisations).

Development of data-sharing arrangements to address existing barriers

The success of collaborative commissioning initiatives depends on the ability to pool and analyse data across sectors to identify needs, track outcomes, and support continuous improvement. The adoption of FHIR (Fast Healthcare Interoperability Resources) as a national standard for health data exchange across the entire care — public and private, federal and state-funded — would lay the technical foundation for seamless, secure data sharing to support joint planning and commissioning. Australia's National Healthcare Interoperability Plan 2023–2028 already commits governments to identity, standards (including FHIR), information-sharing, and benefits measurement. These commitments should be explicitly referenced in commissioning schedules and funding agreements. Common outcome sets should include nationally recognised measures such as potentially preventable hospitalisations (PPH) to link community/primary care action with hospital impacts, alongside patient-reported outcome/experience measures to embed value-based care. Legally, agencies can leverage the Data Availability and Transparency Act (DATA) 2022 to share public-sector data under an accredited and auditable scheme, complemented by health-specific privacy and governance arrangements.

The development of data-sharing arrangements should be positioned as a core component of the joint governance framework and should be guided by the following key considerations:

- A national commitment to establishing and maintaining interoperability, supported by development and implementation of technical standards and compliance enforcement, explicitly aligning LHN/PHN digital roadmaps with the Interoperability Plan's actions and the Commonwealth Digital Health Blueprint 2023–2033.
- Implementation supports for all stakeholders across the care economy, including are general practices, public hospitals, private hospitals, aged care services, or disability providers, to ensure funding is available for system upgrades to address participation

barriers in a connected care economy, with proportionate supports for rural/remote and smaller providers to avoid widening digital inequities.

- Harmonised privacy and data governance frameworks that enable the safe and lawful sharing of information for commissioning purposes, drawing on the DATA Scheme's accredited users and data-sharing arrangements to standardise risk controls under jurisdictions.
- A nationally-consistent approach to data sharing for population health planning, evaluation, and continuous improvement, supported by relevant technical frameworks and clinical governance structures to main trust and accountability, including a single "report one, use many times" indicator set mapped to *Measuring What Matters* and the PHN framework to reduce burden and improve comparability.
- Genuine investment in digital capability-building, particularly for smaller organisations, rural and remote services, and the community care sector, including provision of technical support, training, and access to shared tools for data analytics and performance monitoring. Where feasible, commissioning should incorporate patient-reported measures (PROMs/PREMs) and NSW's practical tooling experience (e.g. HOPE platform) as models for scalable uptake.

In addition, the following could be considered as part of the design of new joint governance arrangements:

- Outcomes-based funding signals: Tie initial Commonwealth "kick-start" funds to jointly agreed outcomes (starting with PPH reduction), with future tranches adjusted by local performance, mirroring NSW collaborative commissioning's value-based orientation.
- Portfolio transparency: Publish local "collaborative commissioning scorecards" that show shared outcomes, equity measures, and service integration metrics to keep ministers and the public focused on collaboration benefits, not just activity.
- ACCHO partnership assurance: Require evidence of co-design with ACCOs and compliance with Closing the Gap Priority Reforms as a condition of funding approval, responding to independent findings that governments must better share responsibility and resource Aboriginal organisations.

Information request 2.1 (cont.)

How should an outcomes framework be designed to support joint monitoring and reporting? What other factors should be considered for joint monitoring and reporting?

A key barrier to advancing collaborative commissioning in Australia is the absence of a clear, consistent outcomes and evaluation framework that demonstrates its long-term value. While the rationale for integrated, person-centred care is widely accepted, there remains a lack of robust, longitudinal data on the impact of collaborative commissioning, particularly in terms of cost-effectiveness, improved health outcomes, and system sustainability. This evidentiary gap contributes to hesitancy among funders and policymakers, especially in a fiscally constrained environment where short-term returns on investment are often prioritised.

To address this, a well-articulated outcomes framework is essential, not only to support joint monitoring and reporting, but also to build a shared vision for what successful collaborative commissioning looks like. Such a framework should reflect: shared, person-centred outcomes that are meaningful to communities and service users; financial and service delivery targets that align with stakeholder priorities; and supported by incentive structures that reward long-term improvements in health and wellbeing, rather than short-term throughput. Design should explicitly align with existing national infrastructure so partners "report one, use many times" — for example, mapping indicators to the National Preventive Health Strategy and publishing through

the AIHW National Preventive Health Monitoring Dashboard to ensure comparability across jurisdictions. Where relevant, PHN reporting should re-use domains from the PHN Performance and Quality Framework so joint reporting complements, rather than duplicates, Commonwealth requirements.

Importantly, the framework should be co-designed with stakeholders across sectors and communities, ensuring it reflects diverse perspectives and fosters collective ownership. Key domains could include:

- **Partnership:** Collaborative commissioning thrives on strong, trust-based partnerships — particularly those that are community-led and locally grounded. Outcomes in this domain might include: establishment of shared leadership and governance models; evidence of consensus-based decision-making; and active involvement of community-based organisations, with safeguards to avoid tokenistic engagement. International precedents (e.g. NHS Integrated Care Systems' shared outcomes toolkits) show that explicitly documenting partner roles, shared priorities, and data responsibilities improves accountability and reduces duplication.

- **Capacity-building:** Sustainable collaborative commissioning requires investment in the capabilities of all partners, especially smaller and community-based providers. Potential outcomes in this domain should include: dedicated funding to support participation in commissioning processes; training in strategic planning, data literacy, and governance; support structures that empower communities to lead and co-design services. Equity considerations should be embedded (for rural/remote and Aboriginal Community Controlled organisations) with targeted resourcing to avoid widening performance gaps.

- **Digitally-enabled implementation:** Digital technologies should be leveraged to collect, analyse, and share data that demonstrates the value of collaborative commissioning. Outcomes in this domain could include: real-time data collection to inform decision-making; shared digital platforms for monitoring outcomes; regular reporting of outcomes to contribute towards a national evidence base to support scaling and policy reform. Standards-based interoperability (FHIR, national identifiers) should be mandated and tied to the National Healthcare Interoperability Plan 2023–2028 so that PHNs, LHNs and community providers can exchange data securely and consistently.

- **Workforce and leadership:** A skilled, culturally competent workforce is critical to bridging institutional divides and driving innovation. Specific outcomes in this domain could include: a workforce development strategy for embedding a culture of collaborative commissioning; interdisciplinary training in systems thinking, adaptive leadership, and partnership management; secondment and joint leadership opportunities to foster cross-sector collaboration; and ongoing capability-building activities to foster cultural safety, a culture of genuine co-design, and inclusive practice. Patient-reported outcome and experience measures (PROMs/PREMs) should be progressively introduced to capture person-centred value alongside system metrics, consistent with value-based care approaches used in collaborative commissioning pilots.

Information request 2.1 (cont.)

How should LHNs and PHNs partner with ACCHOs and other organisations?

A central consideration in advancing collaborative commissioning in Australia is how Local Hospital Networks (LHNs) and Primary Health Networks (PHNs) should partner with Aboriginal Community Controlled Health Organisations (ACCHOs) and other community organisations. These partnerships must go beyond ad hoc consultation and be grounded in formal, accountable arrangements that reflect the principles of the National Agreement on Closing the Gap. The Agreement's Priority Reforms provide a strong foundation, requiring shared decision-making,

stronger support for the community-controlled sector, systemic transformation to ensure cultural safety, and shared access to regional data. Embedding these principles in local commissioning agreements would create durable, trust-based partnerships that survive leadership changes and fiscal pressures.

The Commonwealth's PHN–ACCHO Guiding Principles provide a practical operating manual for how these partnerships should work. They call for joint needs assessments, board-level representation, culturally safe commissioning processes, and shared accountability for outcomes. Aligning LHN–PHN–ACCHO agreements with these principles would ensure consistency nationwide while leaving room for local adaptation. Similarly, the National Aboriginal and Torres Strait Islander Health Plan 2021–2031 provides a framework for aligning local plans with national priorities, reducing duplication and reinforcing coherence across jurisdictions.

For these partnerships to succeed, ACCHOs must be resourced to participate as equal partners. Too often, Aboriginal organisations are asked to shoulder significant responsibilities without adequate funding or infrastructure. Dedicated resources for analytics, workforce development, and digital capacity are essential. At the same time, mainstream services must also be reformed. Leaders such as Tom Calma[1] have warned that focusing solely on strengthening ACCHOs, while neglecting the cultural safety and accessibility of mainstream services that most Aboriginal and Torres Strait Islander people still use, will limit progress. This underscores the need for a dual strategy: investing in ACCHOs while requiring hospitals and primary care services to improve cultural competence[2], accountability, and inclusivity.

Cultural safety should be a non-negotiable element of any partnership. Frameworks such as the National Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025 provide clear guidance on embedding cultural safety into commissioning. This includes measurable workforce targets, mandatory training, independent feedback channels, and accountability mechanisms built into contracts and service agreements. By making cultural safety a requirement rather than an aspiration, LHNs and PHNs can ensure that prevention programs and care pathways are genuinely inclusive and respectful.

Shared data and evaluation are also critical. Effective commissioning depends on accurate, timely, and culturally appropriate data. Partnerships should adopt national interoperability standards, such as FHIR and commitments from the National Healthcare Interoperability Plan 2023–2028, to enable secure and consistent data exchange. At the same time, data governance must respect Indigenous Data Sovereignty, ensuring that ownership, access, and use are determined in partnership with Aboriginal communities. Mechanisms such as the Data Availability and Transparency Act 2022 can provide accredited pathways for data sharing while maintaining robust protections.

To reinforce accountability, partnerships should strive towards shared outcomes that are meaningful to communities. These should include system-level metrics such as potentially preventable hospitalisations and avoidable emergency department presentations, alongside person-centred indicators like patient-reported outcomes and experiences. Publishing these results in a transparent regional dashboard would strengthen community trust and provide funders with evidence of impact. Other communication strategies that are valued by the local Aboriginal community should also be considered as part of this reporting process. Funding arrangements could further reinforce accountability by tying a portion of LHN and PHN resources

[1] Taylor, P (2025, May 6). Tom Calma call to change Indigenous Closing the Gap strategy. *The Australian.* Accessed online: https://www.theaustralian.com.au/nation/indigenous/tom-calma-call-to-change-indigenous-closing-the-gap-strategy/news-story/1cba1ccf0e136793fe6398075767b82e

[2] Laverty, McDermott & Calma. (2017). Embedding cultural safety in Australia's main health care standards. *MJA.* Accessed online: https://www.mja.com.au/journal/2017/207/1/embedding-cultural-safety-australias-main-health-care-standards

to progress against these shared outcomes, with safeguards to protect equity and long-horizon programs from premature defunding.

Finally, the structure of local governance matters. Evidence from NSW's collaborative commissioning pilots and international examples such as the NHS integrated care systems shows the importance of formal local committees with pooled budgets, clear mandates, and equal representation from community organisations. These governance structures reduce fragmentation, support joint accountability, and ensure that ACCHOs and community partners are present and engaged at the decision-making table rather than on the periphery.

In summary, LHNs and PHNs should partner with ACCHOs and other organisations through formalised, well-resourced, and culturally safe arrangements that embed Closing the Gap reforms, adopt national guiding principles, and commit to shared outcomes and transparent reporting. This requires not only empowering ACCHOs with resources and decision-making authority but also reforming mainstream services to ensure inclusivity and cultural safety. With robust data governance, outcome-based commissioning, and strong joint governance structures, these partnerships can move beyond symbolic collaboration to create sustained, systemic change in health outcomes.

Reform of funding arrangements to support integrated, outcome-based care models

Information request 2.2

What levels of resourcing are required to: first, support enhanced joint governance requirements; and second, provide sufficient dedicated funding for collaboratively commissioned services?

Effective collaborative commissioning requires a multi-tiered resourcing approach, encompassing financial, human, technical, and relational capital. This approach must be underpinned by a genuine, long-term investment in governance structures that enable meaningful outcomes and sustained collaboration.

Joint governance arrangements must be supported by a shared vision and purpose, with clearly defined roles and responsibilities across all participating stakeholders. Key resourcing considerations include:

- Dedicated personnel: Strategic leads, partnership managers, data analysts, and legal advisors from each stakeholder group to support coordination, decision-making, and compliance. Commissioning budgets should include provisions for backfilling clinical and frontline roles so staff can attend planning workshops, contribute to co-design processes, and help evaluate outcomes without compromising core service delivery.
- Capacity-building: Tailored training programs to build cross-sector collaboration skills, adapt models of care, implement shared decision-making, and manage conflict where policies or procedures intersect.
- Fit-for-purpose infrastructure: Shared digital platforms (ideally interoperable with existing systems), robust data-sharing protocols, and governance frameworks that support transparency and accountability.
- Dedicated funding for embedded evaluation: Resourcing for independent evaluation activities from the outset, with funding tied not only to service delivery but also to learning and improvement, would ensure that data collection, analysis, and feedback loops are built into ongoing service delivery as part of quality improvement initiatives.

These resources are essential to ensure that all partners can engage meaningfully in joint decision-making and governance processes.

Collaborative commissioning is often hindered by fragmented funding and governance arrangements, as noted by CHA in its response to the Pillar 4 Inquiry. Responsibilities for funding and service delivery are split across federal and state governments, public and private funders, and various sectors, creating incentives to shift costs rather than share them.

To overcome these barriers, the following funding strategies for collaboratively commissioned services should be considered:

- Pooled or bundled funding models: Combining resources from all participating stakeholders to support shared priorities and reduce duplication.
- Outcome-based funding: Allocating funding based on the achievement of shared, person-centred outcomes rather than siloed outputs. This approach encourages long-term improvements in health and wellbeing over short-term throughput.
- Flexible funding mechanisms: Enabling innovation and responsiveness to local community needs by avoiding rigid regulatory constraints and allowing for adaptive service models.
- Joint accountability frameworks: Performance should be measured against shared outcomes, with incentives aligned to collaborative success rather than individual budget targets.

These funding arrangements should be formalised through intergovernmental agreements or memoranda of understanding, which clarify roles, contributions, and risk-sharing mechanisms.

Information request 2.2 (cont.)

What types of funding could be pooled to support collaborative commissioning?

How should the funding adjustment be implemented in practice? What unintended consequences could a funding adjustment to incentivise collaborative commissioning have? Are there outcome measures beyond potentially preventable hospitalisations that should be targeted with the incentive?

The types of funding considered in-scope for pooling should be collectively determined by participating stakeholders, guided by a shared understanding of priorities, service needs, and opportunities to reduce duplication. These discussions should aim to identify areas where existing expenditure can be redirected from administrative overheads to frontline service delivery, thereby enhancing the quality and timeliness of care.

Specific examples of opportunities for pooled funding have been described below:

- Administrative and operational expenditure: Routine costs associated with high-volume, commonly used supplies, such as stationery, printing, and other administrative materials, can be pooled to support a cohesive procurement strategy. This not only achieves economies of scale but also frees up resources for direct service provision.
- Facility and infrastructure management costs: Where collaboratively commissioned services are delivered from shared or co-located facilities, maintenance and operational costs (e.g. utilities, cleaning, security) can be jointly funded. This ensures equitable contribution and supports sustainability of shared service environments.
- Climate and health adaptation initiatives: The health and care sectors face growing demands to respond to climate-related risks. Pooling resources for staff training, strategic planning, and development of best-practice policies enables scalable, sector-wide approaches to climate resilience. This includes investment in energy-efficient

infrastructure, emergency preparedness, and environmentally sustainable models of care.

- Digital infrastructure and interoperability standards: Investment in shared digital infrastructure is critical to enabling joint planning and commissioning. For example, pooling resources to support the adoption of FHIR (Fast Healthcare Interoperability Resources) standards can facilitate seamless data exchange across systems and organisations. This includes funding for technical integration, workforce training, and governance frameworks to ensure secure and effective use of shared data.

Design considerations of a funding adjustment for collaborative commissioning

To support the transition toward collaborative commissioning, a funding adjustment could be initiated through a once-off grant scheme designed to pilot the feasibility of pooled funding mechanisms and joint governance arrangements.

A practical starting point would be the establishment of a competitive grant program, inviting expressions of interest (EOIs) from organisations or partnerships willing to trial collaborative commissioning models. This approach allows for targeted investment in regions or sectors with readiness and capacity to lead innovation. Eligibility and selection criteria should reflect the key considerations outlined earlier, including governance readiness, capacity for joint decision-making, and alignment with shared outcomes. The grant scheme could support activities such as establishing joint governance structures, pooling operational and infrastructure costs, and implementing shared digital systems (e.g. FHIR standards). Importantly, grant funding should be directed toward initiatives that demonstrate potential for scalable, sustainable impact.

An opt-in system would encourage genuine, values-aligned partnerships. By allowing organisations to voluntarily participate, the scheme fosters collaboration based on a shared vision for meeting local care needs, rather than compliance-driven engagement. This model supports local ownership and ensures that participating stakeholders are committed to co-designing and co-delivering services. It also enables flexibility in tailoring commissioning approaches to the unique needs of different communities and service ecosystems.

Above all, these design considerations for a funding adjustment should be aligned with the proposed governance framework (or structure) to enable collaborative commissioning. A well-designed pilot funding adjustment, delivered through a grant scheme with clear criteria and an opt-in model, provides a practical pathway to test and refine collaborative commissioning approaches. It enables stakeholders to build the necessary governance, infrastructure, and partnerships while aligning funding with shared outcomes.

To support the effective implementation of a funding adjustment and joint governance arrangement, it is essential to establish a clear strategy for embedded monitoring and evaluation. This will enable the collection of evidence-informed insights from pilot initiatives, guide broader system reform, and allow for course correction if unintended consequences arise. Monitoring and evaluation should be designed to track progress against shared, person-centred outcomes; identify and address unintended consequences early on; and support iterative refinement of implementation activities.

A key risk to manage is the potential for unintended precedent-setting, where funding adjustments create expectations for similar arrangements across other sectors or groups. If not carefully scoped, this could lead to inequitable access to funding, particularly if certain providers, such as large, well-resourced corporations, are better positioned to advocate for or absorb funding than smaller, not-for-profit organisations. This may inadvertently exacerbate existing disparities in capacity, influence, and service reach.

Therefore, successful implementation must also include deliberate consideration of power dynamics within collaborative commissioning settings. Larger providers may hold

disproportionate influence in decision-making due to their scale, resources, or market position. To ensure equitable participation in the collaborative commissioning process:

- Governance structures should promote inclusive representation, ensuring smaller providers and community-based organisations have a meaningful voice.
- Funding criteria and decision-making processes should be transparent and equity-focused, with safeguards to prevent dominance by any single stakeholder group.
- Scope management protocols should be in place to maintain the integrity of the funding adjustment and avoid scope creep.

By embedding robust evaluation, scope management, and equity safeguards, alongside a conscious approach to balancing power, the funding adjustment can support genuine collaboration and deliver improved outcomes without reinforcing structural inequities and siloes within the care economy.

Outcome measures for collaborative commissioning

As CHA outlined in its response to the PC's Inquiry on Pillar 4, a key barrier to advancing collaborative commissioning in Australia is the lack of clear, consistent evidence and evaluation frameworks that demonstrate its value. Shared understanding and buy-in from the care sectors regarding these outcome measures, particularly in terms of cost-effectiveness, health outcomes, and system sustainability, should be prioritised in the development of a framework to support collaborative commissioning.

Examples of these indicators for measuring success could include the following:

- Progress towards health equity, particularly the accessibility of care services measured by changes in service utilisation rates by socioeconomic status, geography, cultural background and/or other factors
- Service integration, such as the extent to which the collaboratively commissioned service is integrated into broader models of care adopted by participating organisations
- Patient-reported outcomes, including experience of care measures disaggregated by population groups of interest
- System efficiency, including wait times, continuity of care metrics, timeliness of discharges
- Contribution toward local priorities, such as the extent to which there has been representation of community leaders in decision-making processes, or whether care needs of specific cohorts are being addressed.

To foster a strong culture of monitoring and evaluation across all levels of government and sectors, key indicators must be shared, well-understood, and consistently applied from the outset of collaborative commissioning initiatives through to their evaluation. These indicators should be systematically integrated into existing performance monitoring frameworks to ensure alignment with broader system goals and accountability mechanisms.

As previously noted, dedicated funding for embedded evaluation is a critical enabler. It supports both the development of robust, equity-sensitive indicators and the ongoing monitoring of their relevance and effectiveness in diverse contexts. This ensures that evaluation activities remain responsive to local needs and adaptable to emerging insights. Importantly, consistent use of shared indicators helps build trust among stakeholders, enables meaningful comparison across initiatives, and supports continuous improvement.

Information request 2.2 (cont.)

What are the costs of existing collaborative commissioning programs? Is there other information that could inform estimates of the benefits of collaborative commissioning?

Costs of existing collaborative commissioning programs

Collaborative commissioning programs may incur a range of costs that span both establishment (intervention) costs and ongoing operational costs. These costs reflect the complexity of coordinating across multiple sectors, organisations, and governance structures.

These are the upfront investments required to initiate a collaborative commissioning program, including:

- Legal and contractual costs: Drafting memoranda of understanding (MOUs), partnership agreements, and service contracts often requires legal expertise. These costs can be significant, especially when navigating complex governance arrangements or ensuring compliance across jurisdictions and provider types.
- Governance setup: Establishing joint governance structures, stakeholder engagement processes, and decision-making protocols.
- Infrastructure investment: Initial capital outlay for equipment, digital systems, or facility upgrades to support integrated service delivery.
- Change management and design costs: Time from executives/clinical leaders for co-design, pathway redesign, and partner engagement; development of shared care protocols and escalation pathways (a major cost driver noted in joint commissioning guidance).
- Data and interoperability setup: Building shared analytics, FHIT-based interfaces, identify management and consent/data-sharing processes in line with the National Healthcare Interoperability Plan 2023–2028.

Once established, programs require sustained resources to operate effectively:

- Labour costs: Time and effort of clinical and non-clinical staff, including allied health professionals, administrative personnel, and transport staff (where relevant). Cost estimates should reflect the full range of contributors to each occasion of service.
- Capital costs: Ongoing maintenance of buildings and equipment, as well as periodic upgrades or replacements.
- Consumables and utilities: Medication procurement, patient education materials, electricity, heating, and administrative supplies.
- Land-related costs: Maintenance or development of land to meet building code standards or service delivery requirements.
- Regulatory compliance: Labour costs associated with meeting regulatory obligations, such as time spent resolving compliance issues or navigating differing standards across sectors.
- Measurement and evaluation: PROMs/PREMs collection, linkage/evaluation costs, and longitudinal monitoring to evidence value (recommended in PHN performance guidance and integrated care literature).

- Program risk/contingency: Provisioning for ramp-up uncertainty, double running costs during transition, and small-provider participation supports so community organisations are not crowded out.

It is also important to consider the distribution of costs and capacity to address cost consequences across different types of providers and organisations participating in a collaboratively commissioned program. Smaller not-for-profit organisations may face disproportionate burdens in absorbing legal, administrative, and compliance costs compared to larger entities. Without careful design and support, these disparities can undermine the equity goals of collaborative commissioning. Targeted capability funding for smaller providers (analytics, digital, governance training) should therefore be built into commissioning budgets.

Estimating the benefits of collaborative commissioning

Collaborative commissioning presents a strategic opportunity to address long-standing concerns around financial sustainability, service fragmentation, and advance climate resilience. By fostering shared accountability for outcomes and spending, it enables a shift in investment toward prevention, early intervention, and more integrated models of care.

While upfront establishment costs, including legal fees for drafting memoranda of understanding or contracts, governance setup, and infrastructure investment, may be significant, these should be viewed as enablers of long-term system transformation. The medium- to long-term benefits, including improved health outcomes, reduced duplication, and more efficient use of resources, have the potential to far outweigh initial costs. However international evaluations caution that measurable reductions in emergency admissions often take several years, underscoring the need for lead/lag indicators for durable funding.

Joint planning between health and social care funders, such as between public hospitals and private health insurers or between Medicare and state health systems, can reduce cost-shifting and unlock operational efficiencies. As previously stated, pooling funds or aligning incentives can also break down barriers between funding siloes that too often impede innovation. Emerging evidence from United Kingdom integrated models shows substantial reductions for targeted cohorts (e.g. frailty, with reported drops in emergency department use and admissions when multidisciplinary, place-based care is commissioned jointly, illustrating the potential scale of benefits when pathways are redesigned end-to-end.

In light of financial pressures in the private hospital sector, government-led joint procurement initiatives could reduce costs, support local job creation, and minimise medical waste. This would result in greater impact with Australian climate and health adaptation efforts and support the entire hospital sector as a leader in managing climate-related risks. Therefore, presenting one example of where collaboratively commissioned approach could deliver significant community benefits through optimisation of healthcare infrastructure and medical supply procurement. Beyond procurement, the largest “benefit reservoir” is avoidable acute care. In 2023–24, AIHW reports ~778,000 potentially preventable hospitalisations, which is around 6.2 per cent of all hospitalisations. This provides a concrete baseline for modelling avoided activity under collaborative commissioning. Potentially preventable hospitalisations is a recognised proxy for primary/community care effectiveness and is already disaggregated by PHN and small area, enabling local benefit estimates and equity tracking.

Moreover, when commissioning is led by or meaningfully involves local providers, community organisations, and consumers, services are more likely to reflect the unique demographics, social determinants, and health priorities of each region. This is particularly critical in rural and remote areas, where mainstream models often fall short. Shared commissioning arrangements empower local decision-makers to tailor solutions, such as integrating aged care and disability supports with primary and acute care, that are difficult to achieve through top-down funding models alone. Using the Commonwealth’s PHN Performance and Quality Framework

domains/indicators for joint plans helps ensure that local innovations “roll up” to national outcomes and reduces reporting burden (“report one, use many times”).

While some benefits, such as community responsiveness and systemic integration, may be difficult to quantify, they are nonetheless essential to understanding the full impact of collaborative commissioning. These qualitative improvements should be considered alongside financial metrics when estimating the value of such initiative. To strengthen quantification, use a common economic table (e.g. CBAx style) to monetise cross-sector outcomes, and build data access via the Data Availability and Transparency Act 2022 Data Scheme for accredited, auditable sharing of public sector data for commissioning analytics. This combination enables credible benefit-cost estimates for joint proposals and transparent tracking of realised savings across portfolios.

The next addendum of the National Health Reform Agreement (NHRA)

The Productivity Commission’s Interim Report represents a significant contribution to the national reform agenda, offering a clear and evidence-based pathway to improve integration, accountability, and outcomes across the health and disability systems. With Health Ministers agreeing in June 2024 that these reforms should be progressed in tandem with the next National Health Reform Agreement (NHRA), there is now a unique opportunity to align momentum across portfolios and embed structural enablers that support long-term, person-centred reform.

The NHRA is a critical lever to operationalise the Commission’s recommendations, particularly in embedding collaborative commissioning pathways within broader funding and governance reforms. While this submission outlines practical proposals to advance these goals, it also recognises the foundational policy and structural work required through the NHRA process to ensure these reforms are sustainable and system-wide.

To move beyond high-level commitments, the next NHRA addendum must clearly articulate expectations for local partnerships, shared accountability, and integrated service delivery. This includes mandating specific mechanisms to support collaborative commissioning, such as:

- Joint needs assessments, planning, and reporting between LHNs, PHNs, and ACCHOs.
- Formal joint committee structures with specified membership, authority, and accountability, as recommended by the mid-term review’s call for better governance mechanisms.
- System-level accountability pathways, such as requiring the new national governance architecture to report annually to the Health Ministers’ Meeting, embedding joint commissioning into national oversight.

Further, the next addendum should also reconfigure funding flows to reward integrated, outcomes-based performance. This shift is essential to embed value-based healthcare principles across the system, ensuring that funding incentivises not only treatment but also prevention, equity, and long-term health outcomes. Initial examples are outlined below, with Section 3 providing further detail on the breadth of preventative health measures and outcomes central to value-based healthcare.

- Dedicated funding for integrated care models, enabling PHNs, LHNs, and partners to commit staff, infrastructure, and data capacity to joint initiatives.
- A potentially preventable hospitalisation linked payment adjustment, so jurisdictions that demonstrably reduce potentially preventable hospitalisations receive incremental funding allocations.

The mid-term review also highlights digital health and funding innovation as essential enablers to reform. Specifically, the next addendum should:

- Reference national commitments to digital interoperability (e.g. through the National Healthcare Interoperability Plan 2023-2028), embedding data-sharing and analytics capability within collaborative commissioning schedules
- Support establishment of an Innovation Fund accessible under the Agreement, which could seed scalable, co-commissioned pilots nationally, aligning with the recommended 'Funding Innovation Pathway.' One example of this could be the National Preventative Investment Fund (refer to Section 3 of this submission for more detail).

Addressing other barriers to collaborative commissioning

Information request 2.3

What else needs to be considered to implement the reform? How should the mismatched boundaries between LHNs, PHNs, ACCHOs and other organisations be addressed in implementing the different elements of the proposed reform?

Bridging cultural and organisational differences

As CHA previously noted in our response to the Inquiry, and throughout this submission, cultural and organisational differences remain a significant barrier to effective collaboration, and by extension, to the successful implementation of collaborative commissioning. Health, aged care, disability, and community sectors each operate with distinct professional languages, governance structures, and measures of success. Building trust and mutual understanding takes time, especially where organisations have historically competed for funding or operated in silos.

Power imbalances, such as those between government agencies and small community-based organisations, or between funders and service providers, can further undermine partnership efforts. If collaborative commissioning is perceived as top-down or tokenistic, it risks disengagement, resistance, and ultimately, failure to deliver meaningful change.

To address these challenges, Australia must invest in structures and processes that deliberately foster trust, mutual respect, and shared purpose across sectors. One practical approach is the establishment of regional commissioning collaboratives or alliances, co-led by representatives from diverse sectors — public and private, large and small — and inclusive of consumer voices. These collaboratives should be supported by long-term funding and governance arrangements that recognise the time and relational work required to build and sustain effective partnerships.

Crucially, these partnerships must be designed to shift power dynamics, ensuring that all stakeholders, particularly community-based organisations and Aboriginal Community Controlled Health Organisations (ACCHOs), have an equal say in planning and decision-making. This requires moving away from rigid, funder-led models toward genuinely co-designed processes, supported by:

- Shared leadership models that distribute authority equitably.
- Consensus-based governance that values diverse perspectives.
- Transparent decision-making frameworks that build trust and accountability.

It is also essential to recognise that Local Hospital Networks (LHNs), Primary Health Networks (PHNs), ACCHOs, and other organisations operate within distinct local contexts, which vary significantly across jurisdictions. Therefore, partnership models must be flexible and tailored to reflect the unique needs, capacities, and cultural considerations of each region. A one-size-fits-all

approach will not work: instead, collaborative commissioning must be adaptive, responsive, and grounded in local realities.

Supporting workforce capacity and leadership

Workforce capacity and leadership are often overlooked barriers. Effective collaborative commissioning requires skilled leaders who can bridge institutional divides, facilitate consensus, and drive innovation. It also demands time and effort from frontline staff to engage in planning processes, contribute data, and adapt to new ways of working. In under-resourced systems, where staff are already stretched, this additional burden can limit the capacity for collaboration. As noted in a previous subsection, without dedicated resourcing, collaboration risks becoming an unfunded mandate rather than a meaningful reform.

Australia should also invest in a national leadership development strategy for collaborative commissioning, targeting emerging and existing leaders across health, aged care, disability, and social services. This could include interdisciplinary training programs focused on systems thinking, adaptive leadership, and partnership management, as well as secondment opportunities and joint leadership roles that promote cross-sector experience and relationships. As part of the training and development strategy, there should be a sustained focus on building capability in collaborative commissioning, with a strong emphasis on cultural safety. This includes equipping staff with the skills to engage respectfully with diverse communities, co-design services with cultural competence, and embed inclusive practices that reflect the needs and values of all population groups.

PHNs, LHNs, and peak bodies all have a role to play in supporting this leadership capability, but support from governments is essential. Just as important is recognising that community organisations and Aboriginal Community Controlled Health Services often operate with lean structures and need targeted support to engage fully.

Information request 2.3 (cont.)

Are additional supporting actions by governments needed? How can state and territory governments best support and lead change?

The interim report outlines the critical role of state and territory governments in leading systematic change, particularly in guiding LHNs to embed collaborative behaviours with PHNs, ACCHOs, and other key sector partners. Proactive leadership is required in the following areas.

Firstly, the design and implementation of a policy framework for collaborative commissioning. This policy framework should set a clear direction for collaborative commissioning, articulating shared goals and indicators of success that is relevant to the jurisdiction. This may include indicators such as progressing health equity for a population of interest, strengthening service integration between specific service types, improvements to patient-reported outcomes, or enhanced system efficiencies. Importantly, the framework should allow for flexibility for local innovation and responsiveness to community priorities. Establishment of a common language and expectations, the framework can promote alignment across stakeholders and influence the development of enduring partnerships.

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.

While not specifically related to advancing collaborative commissioning, this policy framework provides a guiding blueprint towards a collaborative landscape within the Victorian health context. 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.

Secondly, to ensure accountability and continuous improvement, the policy framework must be underpinned by a comprehensive evaluation plan. This plan should include agreed-upon indicators that reflect person-centred outcomes aligned with the goals of integrated care, such as improved patient experience, reduced avoidable hospitalisations, enhanced capability-building, and strengthened continuity of care. Each indicator should be assessed against transparent evaluation criteria to generate actionable insights. Sharing these insights across stakeholders will not only support learning and adaptation but also reinforce accountability and trust in the commissioning process.

Together, these two elements — policy and evaluation — form the foundation for a sustainable and impactful approach to collaborative commissioning, enabling state and territory governments to lead with clarity, consistency, and purpose.

Addressing legacy structures

Commissioning models are often constrained by rules that limit flexibility in how funding is used, what services can be commissioned, or which outcomes are measured. Programs and incentives are frequently designed in isolation, with limited regard for cross-sector alignment. These legacy arrangements can create fragmentation, duplication, and misaligned priorities across the system. Moreover, well-intentioned reforms, such as performance targets or competitive tendering, can inadvertently reinforce silos and short-termism, undermining collaboration and progress toward a sustainable care economy.

There is an underlying need for specific and deliberate policy work that is focused on identifying and addressing these legacy structures. Specific initiatives could include mapping of existing programs and their funding streams, that may have been developed in isolation, and assess their alignment with collaborative objectives; developing strategies for change to adapt or transition these legacy programs, with clear supports to relevant stakeholders to enable this transition; and embedding policy levers that support integrated service delivery, local innovation and cross-sector partnerships, such as those outlined in previous subsections of this response.

A staged approach to reform is essential, not only to guide future policy design but also to manage the transition of existing systems in a way that is practical, inclusive, and sustainable. By addressing both the legacy and future dimensions of collaborative commissioning policy, governments can create the conditions for genuine collaboration, system transformation, and improved outcomes for communities.

Information request 2.3 (cont.)

How can this proposed reform be employed to further integrate and expand place-based approaches across the care sector?

Aligning funding to outcomes across care sectors

As previously outlined, reforming funding models is essential to achieving the objectives of integrated care. A major barrier is the structural fragmentation between funding sources, particularly between Commonwealth and state/territory governments, and across health and aged care systems. This misalignment often leads to perverse incentives and cost-shifting, with limited accountability for outcomes across the full continuum of care. For example, hospitals may discharge patients prematurely to manage costs, while aged care providers lack the clinical capability or resources to manage complex needs, resulting in preventable readmissions.

To address these challenges, funding must be aligned to outcomes rather than activity. Mechanisms such as bundled payments, shared savings models, and pooled budgets can incentivise collaboration, prevention, and continuity of care. These models reward value over volume, encouraging providers to work together to achieve shared goals such as improved patient experience, reduced avoidable hospitalisations, and better health equity.

A critical enabler of this shift is the support for care professionals to work at their full scope of practice. Outcome-based funding models can help remove restrictive rules and legacy funding siloes that limit the roles of nurse practitioners, pharmacists, and allied health professionals, particularly in primary and aged care settings. Enabling these professionals to prescribe, refer, coordinate care, and access diagnostics not only improves efficiency and workforce sustainability, but also strengthens team-based care and integrated service delivery.

This is especially important in regional, rural, and remote areas, where workforce shortages and service gaps are more pronounced. In these contexts, place-based approaches supported by outcome-based funding can enable locally tailored solutions that reflect community priorities and cultural contexts. For example, aged care nurses working at the top of their scope, supported by remote clinicians and digital health tools, can dramatically improve access and reduce avoidable hospital transfers. Similarly, flexible commissioning can support outreach, telehealth, and community-led models that are responsive to local needs.

Finally, aligning funding to outcomes in a place-based model allows health and social services to be integrated with broader regional development goals, supporting local employment, capacity-building, and community resilience. This approach not only improves care but also strengthens the social and economic environment of regional communities.

Embedding public-private partnerships to expand on collaboratively commissioned programs

A further example to expand place-based approaches across the care sector is through targeted public-private partnerships to deliver innovative, cost-effective solutions that support long-term fiscal sustainability and improved health outcomes.

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.

Section 3: A national framework to support government investment in prevention

CHA strongly supports Draft Recommendation 3.1 and the establishment of a national framework to guide government investment in prevention. Such a framework is essential to ensure consistent, strategic, and equitable funding across the care continuum. Crucially, it must recognise that prevention is not one-size-fits-all, with programs targeting young people differ significantly in design, delivery, and political traction compared to those for older adults or people with disability.

Given the integrated responsibilities of the Department of Health, Disability, and Ageing, a national framework offers a timely opportunity to align investment with the changing acuity and complexity of care needs. By embedding flexibility and responsiveness, the framework can support tailored approaches that reflect the unique needs of different cohorts and care settings, ensuring prevention is prioritised not only for its long-term value but also for its relevance across the continuum of care.

This section of the submission address two components: (1) design considerations of the framework, and (2) design considerations of the funding mechanism to support the framework.

Key recommendations outlined in this section include:

1. **Establish a two-stage assessment process as part of the prioritisation and analysis of different preventative health program proposals.** Firstly, this would include a set of gatekeeping criteria to ensure proposals meet minimum standards for evidence quality, baseline value, implementation readiness, and alignment with national obligations. Secondly, apply a multi-criteria decision analysis (MCDA) framework with published swing-weights that would be set and periodically reviewed by the proposed Prevention Framework Advisory Board.
2. **Support the establishment of the assessment process with a flexible, principle-based evaluation framework for preventative health program proposals.** This should include criteria such as cost-effectiveness, fiscal impact, equity, implementation feasibility, and timescale, with the broader purpose to guide interpretation of economic evaluations associated with these proposals, ensuring that findings are not reduced to a single bottom-line figure.
3. **Set minimum cost-effectiveness or cost-benefit thresholds using context-specific approaches that integrate key economic evaluation tools.** Thresholds should be framed as ranges with clearly defined “modifiers” (e.g. severity, unmet need, equity impacts, strategic importance, externalities), rather than a single fixed cut-off, and reviewed periodically by the proposed Prevention Framework Advisory Board (PFAB).
4. **Embed monitoring and evaluation functions from the outset of program implementation to balance early program effectiveness with sustained investment in long-term benefits.** This would include adoption of a “lead and lag” indicator framework, where early process and behavioural indicators (such as service uptake, adherence, or risk-factor reduction) are systematically linked to later health and economic outcomes. A shift in funding structures from ad hoc grants to multi-year, rolling commitments that are contingent on credible progress rather than immediate impact, as informed by evaluation findings, would also be required.
5. **Design diversification strategies for prevention funding as a managed portfolio rather than a collection of disconnected projects**. This should reflect or be aligned with: the maturity of evidence, use of consistent whole-of-government valuation methods, multi-year rolling commitments to ensure accountability, and a culture of transparent reporting through a publicly available dashboard based on key indicators.

6. **Support the implementation of a National Prevention Investment Framework with a clear, government-led strategy and implementation plan.** Progress should be tracked through transparent public reporting, drawing on existing national infrastructure to keep outcomes visible across governments and the community. Indicators should be structured as “lead and lag” measures to show early fidelity/uptake signals while longer-run health and fiscal outcomes mature.
7. **Embed outcomes-based measures into existing performance and accountability measures.** These measures should track progress, foster a culture of learning and improvement, acknowledge strengths and limitations of current investment approaches, while providing evidence to support a sustained focus on prevention.
8. **Develop a publicly accessible dashboard that tracks progress against key outcome indicators.** Key outcome indicators could include service access rates or reductions in preventable hospitalisations. Regular reporting of these metrics at forums such as the Health Ministers Forum would keep these indicators front-of-mind for decision-makers and promote cross-jurisdictional accountability.
9. **Establishment of a National Prevention Investment Fund to support the Investment Framework.** As part of this, develop assessment guidelines and principles in consultation with key sector stakeholders, provide clear and consistent advice to organisations participating in the submission process, and undertake further policy development to address potential gaps and ensure coherence across sectors.
10. **Targeted adjustments to the existing budget operational rules are needed to support the PFAB recommendations.** This should include the creation of a new gateway in the New Policy Proposal (NPP) pathway, and other amendments relating to existing rules around cross-portfolio NPPs.
11. **Ensure that formal joint arrangements are in place to support coordinated governance and implementation of the National Prevention Investment Framework**. This may include: the development of specific schedules and funding arrangements in consultation with a diverse range of stakeholders; development of a co-contribution amount calculation tool; and broader work to harmonise evidence and reporting requirements with current data collection practices.
12. **Design the National Prevention Investment Framework with the view to ensure it is embedded within state and territory government programs.** By embedding initiatives in Federation Funding Agreements (FFA) schedules, harmonising indicators, adopting common valuation tools, securing continuity through portfolio rules, aligning incentives with benefit-sharing, and ensuring transparency through public dashboards, the framework would not only respect but also reinforce existing prevention efforts.

Designing a framework for the analysis of prevention programs

Information request 3.1

When prioritising different proposals, how should factors such as overall net benefits, net fiscal effects, cost-effectiveness, equity, ease of implementation, timescale and the value of future benefits and costs be weighted? Are there existing frameworks that do this well?

The experience of CHA and its members highlights that one of the most significant barriers to valuing and prioritising preventive health programs is the dominance of short-term political and budgetary cycles in public policymaking. Evidence-based prevention initiatives often require substantial upfront investment and may only yield measurable outcomes over extended timeframes, well beyond electoral cycles or annual budget reporting periods. In this context, decision-makers under pressure to deliver immediate results may struggle to justify investments in programs whose benefits are delayed, diffuse, or accrue outside their portfolio or jurisdiction.

This political landscape underscores the need to shift focus from immediate net fiscal benefits and bottom-line approaches toward a more strategic valuation of long-term societal gains.

Traditional ‘value for money’ assessments are insufficient for capturing the full scope of benefits associated with prevention. Instead, a broader societal perspective on cost-effectiveness is essential to account for future costs and benefits, equity impacts, and implementation feasibility.

When prioritising proposals, factors like net benefits, fiscal impact, cost-effectiveness, equity, feasibility, and timing must be weighed. Health Technology Assessment (HTA) provides a structured example of how this is done, especially in decisions about funding health interventions.

HTA often uses Multi-Criteria Decision Analysis (MCDA) to assign weights to these factors, enabling transparent and rational priority setting. MCDA extends traditional cost-effectiveness analysis by incorporating broader considerations, such as equity and distribution of health gains, into decision-making. This approach helps justify funding for interventions that may not be the most cost-effective but offer significant social or equity benefits. Agencies like the National Institute for Health and Care Excellence (NICE) and the Pharmaceutical Benefits Advisory Committee (PBAC) use such frameworks to guide funding decisions, often through scoring matrices that reflect the relative importance of each criterion.

To strengthen this approach, CHA supports the establishment of a two-stage assessment process. First, a set of gatekeeping criteria would ensure proposals meet minimum standards for evidence quality, baseline value, implementation readiness, and alignment with national obligations. Second, an MCDA framework with published swing-weights would be applied, covering domains such as net social benefit, cost-effectiveness, equity, fiscal effects, implementation feasibility, and timescale. Weights should be set and periodically reviewed by the proposed Prevention Framework Advisory Board, with results published transparently.

To support this shift, CHA recommends a flexible, principle-based framework for evaluating prevention proposals. This should include criteria such as cost-effectiveness, fiscal impact, equity, implementation feasibility, and timescale. These ‘principles’ should guide the interpretation of economic evaluations associated with these proposals, ensuring that findings are not reduced to a single bottom-line figure. Sensitivity analyses, projections of long-term outcomes, and secondary analyses of longitudinal data can help illuminate the range of plausible impacts, although these methods must be applied with caution, acknowledging limitations in generalisability and population comparability.

An example of a principle-based approach is IHACPA’s Pricing Framework, which outlines the scope, methodology, and principles used to determine the relative costs of public hospital services. Similarly, a national prevention investment framework should embed flexibility to accommodate changing needs and contexts, including nuances of different care settings (i.e. aged care, public hospital, private hospital). This includes recognising the societal and political environment in which a program is proposed, as well as the specific needs of the target population, which is an approach consistent with established program logic models in health evaluation.

To operationalise this flexibility, CHA suggests incorporating a checklist-based appraisal tool, such as Drummond’s framework for critical appraisal of economic evaluations. This would allow assessors to select from multiple options within each domain, with a requirement to justify their rationale. Such a tool would support independent assessment and critical appraisal, while ensuring that evaluations remain responsive to the dynamic and complex nature of preventive health investment. Importantly, the use of systematic tools like this also fosters a culture of transparency, where each step in the valuation process is clearly documented and open to scrutiny. Transparent reporting not only strengthens the credibility of the evaluation but also facilitates stakeholder understanding and trust in the decision-making process for prioritisation of specific program proposal(s) over alternatives.

Finally, decision-making should be optimised at the portfolio level. This means not only ranking individual proposals, but also balancing investments across short-, medium-, and long-horizon interventions, and ensuring material investment in priority populations. This portfolio approach reduces the risk of skewing decisions toward politically expedient programs and ensures long-term preventive impact is not lost and contributes towards a culture-shift that maintains a focus on investment in preventative health initiatives.

Several examples of existing frameworks that cover the identified factors have been described below as case studies, with specific commentary regarding lessons learnt.

Case study: The OECD Recommendation on Public Policy Evaluation

Public policy evaluation is a critical tool for governments to assess the relevance, coherence, efficiency, effectiveness, impact, and sustainability of interventions. In the health sector, where resources are limited and needs are vast, structured evaluation helps policymakers make informed decisions about which healthcare proposals to fund, scale, or refine.

The OECD framework provides a comprehensive guide for governments to embed evaluation into the policy cycle. It is structured around three pillars and seven dimensions:

1. **Institutionalisation**
    - Promotes a whole-of-government approach to evaluation.
    - Strengthens execution and agency across institutions.
    - Fosters a culture of learning and accountability.
2. **Quality**
    - Emphasises strong design, planning, and management of evaluations.
    - Sets quality standards for methods and processes.
    - Builds institutional capacity and skills for effective evaluation.
3. **Impact**
    - Encourages the use of findings in decision-making.
    - Supports accessibility and dissemination of results to stakeholders.

The OECD recommendation provides a foundational starting point for integrating evaluation concepts and principles into priority setting. It ensures that decisions are informed by evidence, aligned with strategic goals, and responsive to societal needs.

More information on the toolkit can be accessed here.

Case study: Drummond's checklist for critical appraisal of economic evaluations

Specific questions contained in the checklist are:

1. Was a well-defined question posed in answerable form?
2. Was a comprehensive description of the competing alternatives given (i.e. can you tell who, did what, to whom, where and how often)?
3. Was the effectiveness of the programmes or services established?
4. Were all the important and relevant costs and consequences for each alternative identified?

5. Were costs and consequences measured accurately in appropriate physical units (e.g. hours of nursing time, number of physician visits, lost work days, gained life-years)?
6. Were costs and consequences valued credibly?
7. Were costs and consequences adjusted for differential timing?
8. Was an incremental analysis of costs and consequences of alternatives performed?
9. Was allowance made for uncertainty in the estimates of costs and consequences?
10. Did the presentation and discussion of study results include all issues of concern to users?

Further information and detail regarding each question contained in the checklist is available here.

Case study: IHACPA's Pricing Framework – Residential Aged Care Pricing Principles

Examples of pricing principles defined by IHACPA in its Residential Aged Care Pricing Principles are as follows:

- **Person-centred:** Funding should be, as far as is practicable, based on characteristics of the people receiving care, rather than those of providers.
- **Fostering care innovation:** Pricing of aged care services should respond in a timely way to the introduction of evidence-based, effective new technology and innovations in the models of care that improve resident outcomes and service efficiency.
- **Stability:** The payment relativities of the AN-ACC funding model should aim to achieve stability in the aged care sector over time.

Further information and detail of this pricing framework can be found here.

Case study: Performance matrix (Baltussen & Niessen, 2006)

Baltussen and Niessen (2006) highlight the limitations of relying solely on cost-effectiveness analysis (CEA) in health priority setting, particularly in low-income countries where decision-making must account for a broader range of societal values and constraints. Their work proposes Multi-Criteria Decision Analysis (MCDA) as a more inclusive framework for evaluating health interventions.

Specific criteria in this study included:

- Cost-effectiveness
- Severity of disease
- Age group targeted
- Poverty reduction potential
- Feasibility of implementation

Each intervention was scored across these criteria, and weights were assigned based on stakeholder preferences. For example, interventions targeting severe diseases or vulnerable populations (e.g. children) received higher scores, even if their cost-effectiveness was moderate.

One key finding was that interventions with lower cost-effectiveness but high equity and feasibility scores, such as community-based malaria prevention, were prioritised over more efficient but less equitable options. This demonstrated how MCDA can support transparent and rational decision-making that reflects societal values beyond economic efficiency.

Further information and guidance on how MCDA can be applied in healthcare decision-making is available here.

Information request 3.1 (cont.)

Should there be minimum cost-effectiveness and/or cost-benefit ratios and how should they be set?

A minimum cost-effectiveness or cost-benefit threshold should be set using a context-specific approach that integrates key economic evaluation tools, namely, incremental cost-effectiveness ratios (ICERs), willingness-to-pay (WTP) thresholds, and cost-effectiveness acceptability curves (CEACs). Together, these tools offer a transparent and probabilistic framework for assessing value of interventions whilst being cognisant of potential uncertainty. Thresholds should be framed as ranges with clearly defined “modifiers” (e.g. severity, unmet need, equity impacts, strategic importance, externalities), rather than a single fixed cut-off, and reviewed periodically by the proposed Prevention Framework Advisory Board (PFAB).

ICERs quantify the additional cost required to gain one extra unit of health benefit, such as a quality-adjusted life year (QALY), when comparing two interventions. To interpret ICERs, decision-makers could use a WTP threshold, which reflects the maximum amount a health system or society is willing to pay for one additional unit of health gain. If an ICER falls below this threshold, the intervention is generally considered cost-effective. However, WTP thresholds should not be fixed; they must be tailored to the specific context, reflecting societal values, budget constraints, and comparisons with similar interventions or services. International practice illustrates this: NICE typically assesses within a benchmark range of about £20,000–£30,000 per QALY, with a severity modifier that can support higher thresholds in defined circumstances; by

contrast, Australia's PBAC does not publish a fixed threshold, relying on deliberative judgment with implicit, context-dependent reference values.

Given the uncertainty and complexity inherent in valuation of preventive health programs, such as variability in costs, outcomes, and assumptions, ICERs alone may not provide sufficient insight. CEACs address this by graphically representing the probability that an intervention is cost-effective across a range of WTP thresholds. Derived from probabilistic sensitivity analysis, CEACs help decision-makers understand the robustness of cost-effectiveness conclusions under uncertainty. For accountability, PFAB should require CEACs and publish (i) the probability an intervention is cost-effective at each relevant threshold and (ii) scenario analyses for key structural assumptions (e.g. uptake, adherence, spillovers).

By combining ICERs, WTP thresholds, and CEACs, decision-makers can establish minimum thresholds that are both evidence-based and contextually relevant. This approach ensures that valuations are grounded in realistic expectations and societal priorities, while also supporting transparent and accountable decision-making. Ultimately, these tools should be embedded within a broader framework that considers equity, feasibility, and long-term impact, particularly when evaluating preventive health programs. Two additional design points strengthen this approach:

- Use "supply-side" (opportunity-cost) estimates to inform local threshold ranges. Empirical work for Australia has estimated reference ICERs based on the marginal productivity of the health budget; PFAB should commission updated estimates and use them as anchors, alongside broader societal considerations for prevention.
- Avoid GDP-per-capita rules of thumb (e.g. 1–3× GDP per QALY). These are no longer recommended for country-level decision-making and can mislead priorities; locally derived thresholds and deliberative modifiers are preferable alternatives.

How to set and apply minimums in practice (recommended additions):

- Publish a default threshold range (e.g. an Australian, empirically anchored range) plus explicit modifiers (severity/shortfall, equity, rarity, externalities, strategic/option value). Document any upward or downward adjustment.
- For cost-benefit analysis, set a base requirement that net present value (NPV) ≥ 0 and benefit–cost ratio (BCR) ≥ 1, and report the modelled probability that benefits exceed costs under uncertainty; this mirrors best practice in prevention portfolios such as WSIPP.
- Require presentation at multiple discount rates (e.g. central plus lower/higher sensitivity) to reflect long-horizon prevention benefits, and pair lagging outcomes with validated leading indicators to avoid penalising long-term programs.
- Avoid treating a threshold as dispositive. Where equity or intergenerational benefits are material, use distributional CEA/CBA alongside the base case and disclose the trade-offs explicitly.

In summary, minimum cost-effectiveness and cost-benefit "thresholds" should exist, but as transparent ranges anchored in local opportunity cost and applied through a deliberative framework with published modifiers and CEACs, rather than rigid cut-offs, so that prevention programs with long-term, cross-sector benefits are not systematically under-valued.

Information request 3.1 (cont.)

How should decision makers balance the need to assess early effectiveness of programs with the need to maintain consistent long-term funding for programs with long-term benefits?

Decision-makers face a persistent tension between demonstrating early program effectiveness and sustaining long-term investment in initiatives with delayed or diffuse benefits. A major barrier is the underdeveloped data and evaluation infrastructure across the care economy. Many

prevention programs are funded through short-term grants, lack rigorous evaluation, and are disconnected from national systems for knowledge translation. This undermines the evidence base and limits scalability. Political visibility is another challenge. Acute care sectors benefit from strong institutional advocacy, while prevention is often fragmented across less influential actors. This imbalance can skew funding toward reactive services rather than strategic, preventative programs.

Traditional cost-benefit analysis (CBA) offers a broader evaluative scope than cost-effectiveness analysis (CEA), enabling cross-sector comparisons and long-term benefit valuation. However, CBAs rely on high-quality data, which is often lacking in early-stage or preventive programs. One approach to bridging this gap is willingness-to-pay (WTP) studies, which capture societal preferences for long-term health outcomes. While methodologically complex, WTP can help justify sustained investment by aligning funding decisions with public values and broader welfare goals.

To effectively balance the need for early program effectiveness with sustained investment in long-term benefits, ongoing monitoring and evaluation must be embedded from the outset. This requires strategic partnerships with evaluation experts and stakeholders across the care economy, guided by a shared vision for long-term impact. A clearly defined theory of change should underpin investment decisions, mapping short-, medium-, and long-term outcomes across a diverse range of programs. This strengthens the evidence base and supports rational, transparent decision-making.

Decision-makers should adopt a “lead and lag” indicator framework, where early process and behavioural indicators (such as service uptake, adherence, or risk-factor reduction) are systematically linked to later health and economic outcomes. This allows funders to demonstrate progress in the short term without prematurely terminating programs that need time to deliver full benefits.

Evaluation cycles should be staged, with light-touch early evaluations focused on feasibility and fidelity, medium-term evaluations focused on intermediate outcomes, and long-term evaluations capturing population-level and fiscal impacts. This staged approach reduces the pressure for programs to demonstrate unrealistic early returns while still holding them accountable for performance.

Funding structures should shift from ad hoc grants to multi-year, rolling commitments that are contingent on credible progress rather than immediate impact. For example, “progressive funding tranches” could release additional investment as programs meet agreed developmental or implementation milestones. This is consistent with practices in venture philanthropy and social impact investing, where staged financing protects against waste while supporting long-horizon returns.

Independent review bodies, such as the proposed Prevention Framework Advisory Board, should oversee evaluation standards, publish transparent assessments, and guard against politically motivated defunding of programs that are performing well on early indicators. This reduces vulnerability to electoral cycles and supports evidence-based continuity.

Cross-jurisdictional benefit-sharing arrangements are also important: if long-term gains accrue to a different level of government than the one funding the program, short-term termination becomes more likely. Mechanisms that align fiscal incentives (e.g. pooled funds or co-funding agreements) can encourage all levels of government to maintain investment.

In parallel, a consistent narrative, supported by transparent appraisal tools and flexible evaluation frameworks, can help shift the focus from short-term fiscal returns to long-term societal value. Embedding this approach within policy and funding structures encourages cultural and

behavioural change, ensuring that preventive programs are valued not only for immediate outcomes but for their enduring impact on population health and wellbeing.

Information request 3.1 (cont.):

How could a diversification strategy be designed to ensure that prevention programs from different sectors and with benefits across different timeframes are funded?

A diversification strategy in the context of prevention funding means deliberately spreading investment across a mix of programs, sectors, and time horizons, rather than concentrating resources on a narrow set of initiatives. The purpose is to manage risk, balance short-term political imperatives with long-term societal gains, and ensure that benefits are realised in multiple parts of the system.

A diversification strategy for prevention funding should be designed as a managed portfolio rather than a collection of disconnected projects. This requires decision makers to apply portfolio guardrails that ensure programs are spread across multiple sectors, such as health, education, housing, justice, employment, and environment, and across different time horizons, including quick wins, medium-term, and long-horizon initiatives. For example, minimum and maximum shares can be set for each sector, while at least 30 percent of funding could be directed to long-horizon programs to safeguard future returns, with a smaller proportion allocated to short-term initiatives to maintain political visibility. International guidance such as the UK Treasury's Green Book emphasises portfolio appraisal rather than single-project maximisation, and this logic is well-suited to preventive health. Importantly, diversification provides an opportunity to unlock productivity gains and bolster health system performance. An essential component of doing this well would be an embedded focus on value-based healthcare, ensuring that investments not only achieve cost savings but also deliver measurable improvements in health outcomes relative to resources used.

Diversification should also reflect the maturity of evidence. Programs can be grouped into three tiers: innovation pilots with small, staged investments; scaling initiatives with positive evidence in at least one context; and proven programs that warrant sustained funding. This approach mirrors the evidence-based portfolio frameworks of the Washington State Institute for Public Policy (WSIPP), which compares taxpayer costs and monetised social benefits across hundreds of programs, demonstrating that long-horizon prevention can deliver robust net benefits if consistently supported. By adopting such evidence tiers, governments can protect against over-investing in unproven ideas while still nurturing innovation.

Because prevention programs often generate cross-sectoral benefits, consistent whole-of-government valuation methods are also essential. In New Zealand, the Treasury encourages important public sector decisions to be informed by cost benefit analysis (CBA). The CBAx tool offers a strong model, providing common monetised outcomes across agencies so that investments in education, housing, or health can be compared on the same terms at Budget time. This helps prevent fragmentation and supports intentional diversification across the portfolio. Similarly, Victoria's Early Intervention Investment Framework integrates early-intervention spending into the state Budget, linking allocations to quantifiable outcomes across multiple service systems.

Potential pilot

As part of efforts to operationalise the National Prevention Investment Fund (further detail is available in a subsequent section), CHA members propose a series of pilot programs to demonstrate how preventative health initiatives can be implemented, evaluated, and scaled using these tools. These pilots offer a unique opportunity to test the Fund's underlying

framework, particularly its capacity to support integrated, outcomes-based investment across sectors.

One such pilot is the **Nurse Outreach in Ambulance Program**, a cross-sectoral initiative designed to improve care transitions for older Australians. The program embeds a **geriatric-specialised nurse** from a residential aged care facility into the ambulance transfer process, accompanying older individuals who require hospital care. The nurse provides clinical oversight and advocacy during the transfer and hospital admission, with the goal of ensuring timely assessment and facilitating a safe, efficient return to the person's usual residence.

This initiative addresses a known gap in transitional care and presents a strong case for preventative investment. It has the potential to reduce hospital length of stay, prevent avoidable readmissions, and improve patient outcomes, while also relieving pressure on emergency departments and inpatient services.

The National Prevention Investment Fund could be used to overcome current funding and coordination barriers that span aged care, ambulance, and hospital systems. By applying the proposed valuation framework to this pilot, stakeholders can:

- Test the feasibility of integrated funding models across jurisdictions and sectors;
- Assess the return on investment using whole-of-government valuation methods, including avoided hospital costs, improved aged care outcomes, and enhanced patient experience;
- Generate scalable evidence to inform broader reform and investment strategies in preventative health.

This case study exemplifies how the Fund can catalyse innovative, cross-sectoral solutions that align with value-based healthcare principles and deliver measurable outcomes for individuals and the system.

To balance accountability with long-term investment, funding should move away from short-term grants and toward multi-year rolling commitments. These could be structured as progressive tranches that release additional investment as programs meet agreed developmental or implementation milestones. Coupled with a "lead and lag" indicator framework, this approach ensures that early signals, such as program uptake or behaviour change, are tracked, while programs that require time to deliver population-level benefits are not prematurely defunded. Oversight by an independent body, such as the proposed Prevention Framework Advisory Board, would further safeguard against politically motivated shifts by publishing transparent assessments and monitoring sectoral and time-horizon balance.

Finally, diversification should be tracked and reported through a public dashboard that shows how much funding is going to each sector, the share of investments across short-, medium-, and long-term horizons, the evidence maturity of funded programs, and expected fiscal and equity impacts. Transparent reporting strengthens accountability and public trust, ensuring that prevention investment is understood not simply in terms of immediate returns but as a balanced portfolio of initiatives designed to deliver benefits across multiple sectors and timeframes. By adopting this approach, anchored in Green Book-style appraisal, CBAx valuation, WSIPP evidence libraries, and a clear commitment to value-based healthcare, governments can institutionalise diversification and create a prevention funding framework that is resilient, equitable, and focused on long-term societal gains.

Designing a funding mechanism to support eligible prevention initiatives

Information request 3.2

How should a National Prevention Investment Framework be implemented? What is the best way to incentivise Australian, state and territory governments to invest in prevention to improve future outcomes and avoid future costs?

Implementation considerations of a National Prevention Investment Framework

As outlined in CHA's response to the Productivity Commission, governments should take a leadership role in investing in prevention initiatives by actively role-modelling best practices. A key implementation consideration is the prioritisation of strategic partnerships and the integration of collaborative commissioning as a central element of investment decisions. This will require addressing known barriers and establishing joint funding arrangements that embed collaborative commissioning across the care economy, with a strong emphasis on coordinated action in prevention. International practice shows that implementation is most durable when portfolio appraisal is built into the budget process (rather than stand-alone grants) and when a common valuation method is used across sectors (e.g. HM Treasury's Green Book portfolio approach and New Zealand Treasury's CBAx tool).

To ensure sustained and effective implementation, this approach must be underpinned by a clear, government-led strategy that guides national efforts and aligns stakeholders around shared goals. The implementation of the National Prevention Investment Framework should be supported by a detailed, actionable plan that enables strategic, evidence-informed decision-making. This plan should include measurable progress indicators and align with existing national policies, such as the National Preventive Health Strategy 2021–2030. Progress should be tracked through transparent public reporting, drawing on existing national infrastructure such as the AIHW's National Preventive Health Monitoring Dashboard, to keep outcomes visible across governments and the community. Where feasible, indicators should be structured as "lead and lag" measures to show early fidelity/uptake signals while longer-run health and fiscal outcomes mature. CHA's submission to the Productivity Commission includes specific recommendations for the action plan, which can be accessed here.

Moreover, a robust implementation plan will facilitate ongoing progress reporting and formative evaluation against key outcome indicators. This will enable refinement of initiatives, course correction for long-term programs, and continuous reinforcement of the value of sustained investment in prevention. It will also support timely reporting of tangible benefits, such as cost savings, to governments and stakeholders. Jurisdictions can draw on worked examples like Victoria's Early Intervention Investment Framework (EIIF), which links budget proposals to quantifiable early-intervention impacts and publishes tools/templates to operationalise this approach.

Opportunities to incentivise governments to invest in prevention

There are multiple approaches to incentivising governments to invest in prevention, with the overarching goal of improving future outcomes and avoiding escalating costs. A practical and impactful strategy is the integration of outcome-based measures into existing performance and accountability frameworks. These measures should be designed not only to track progress but also to foster a culture of learning and continuous improvement across jurisdictions. They should acknowledge the strengths and limitations of current investment approaches while reinforcing a sustained focus on prevention. Incentives should explicitly recognise cross-portfolio benefits (e.g. education, housing, justice) by valuing outcomes consistently across sectors, following models such as CBAx and the Green Book's guidance on multi-objective, portfolio-level appraisal.

To provide a tangible benchmark, a staged increase in the proportion of government investment portfolios dedicated to prevention could be implemented. For example, governments could

commit to allocating a minimum percentage of their health or social investment budgets to prevention activities, with this proportion increasing incrementally each financial year. This would signal a sustained and deliberate shift toward future-readiness and enable tracking of investment volume over time. One example of this in practice is the commitment by the Victorian Government, which has averaged a yearly budgetary allocation of $833 million for prevention between 2023-24 and 2025-26 under the Early Intervention Investment Framework (DTF 2024b, 2025). National targets should also align with the direction of the National Preventive Health Strategy and be publicly tracked (e.g. via the AIHW dashboard) to reinforce accountability across electoral cycles.

Another opportunity lies in the development of a publicly accessible dashboard that tracks progress against key outcome indicators, such as service access rates or reductions in preventable hospitalisations. Transparent, tangible metrics would support strategic service planning and incentivise coordinated action, including collaborative commissioning to address local priorities. Regular reporting of these metrics at forums such as the Health Ministers Forum would keep these indicators front-of-mind for decision-makers and promote cross-jurisdictional accountability. Dashboards should also show the “portfolio mix” (shares by sector, time horizon, and evidence maturity) to guard against over-concentration on short-term wins, which is a technique recommended in international appraisal guidance.

To ensure these efforts are meaningful, progress in prevention investment must be recognised and rewarded in ways that go beyond symbolic gestures. Safeguards should be in place to prevent reporting from becoming a ‘tick-box’ exercise, particularly when outcome reporting is mandated. Mechanisms that move funding when outcomes move, such as staged/contingent budget releases tied to pre-agreed milestones, can maintain discipline without penalising long-horizon programs. WSIPP-style benefit-cost models can inform these gates by estimating long-run social and fiscal returns.

As previously noted, the pursuit of long-term cost savings and improved health outcomes through prevention is often constrained by the immediate financial pressures within the care economy. This challenge is especially evident in climate and health adaptation initiatives, where future benefits can be difficult to communicate to decision-makers facing urgent operational demands. Addressing this requires benefit-sharing rules that align incentives where savings accrue to a different portfolio or jurisdiction than the one that pays. Intergovernmental agreements should include formula-based co-contributions and periodic true-ups as evidence improves (drawing on methods used in cross-government portfolio appraisal).

To overcome these barriers, government-led partnerships are essential to support care providers in shaping the future of the care economy. This requires sustained leadership at the federal level, with cascading effects across state and territory governments. Continued policy debate at the national level is critical to maintain momentum, elevate the importance of prevention, and strike a balance between addressing current system pressures and building a future-ready, fit-for-purpose model of care that prioritises early intervention and prevention. Evidence from Victoria’s EIIF and international practice indicates that embedding early-intervention logics in the Budget (rather than ad-hoc grants) increases durability and signals seriousness to delivery partners.

Establishment of a National Prevention Investment Fund

CHA supports the findings and alternative funding mechanisms set out in the interim report. In particular, CHA strongly recommends the establishment of a National Prevention Investment Fund as the preferred approach. Unlike a modified budget process, a dedicated fund would provide a clear scope, greater transparency, and a sustained medium- to long-term commitment to prevention activities. It would reduce reliance on shifting government priorities across electoral cycles, ensuring continuity and strategic investment in prevention initiatives. The Fund should operate as a managed portfolio with explicit guardrails (e.g. minimum shares for long-horizon

benefits and for non-health sectors) and publish annual statements showing expected benefit–cost ratios, distributional impacts, and the evidence maturity of funded programs.

The interim report outlines a modified budget process in which organisations would collaborate with the Prevention Funding Advisory Board (PFAB) to develop evidence-based proposals for consideration by the Expenditure Review Committee and Cabinet. While the proposed adjustments to this process are reasonable and should be implemented as a suite of reforms, their implementation context must be clearly articulated. This will ensure a shared vision and coordinated approach across stakeholders, should this pathway be preferred. If a modified budget route is chosen, consistent appraisal standards (Green Book-style) and a common valuation tool (CBAx-style) should be mandated to enable cross-portfolio comparisons.

To support effective implementation of the fund alongside the framework, CHA recommends that:

- Assessment guidelines and principles are developed in consultation with key sector stakeholders, used to guide PFAB evaluations, and informs Expenditure Review Committee discussions. These should specify required economic analyses (CBA/CEA with uncertainty), distributional assessments, and agreed discount-rate sensitivities appropriate for long-horizon prevention.
- Consistent advice is provided to organisations participating in the submission process. Standardised templates (similar to EIIF/CBAx) reduce transaction costs and improve comparability.
- Further policy development to address potential gaps and ensure coherence across sectors, given the scope and purpose of the fund. This should include data-sharing protocols and linked datasets to evaluate cross-sector outcomes over time.

However, CHA believes that the establishment of a National Prevention Investment Fund is a more feasible and contemporary solution to meet the needs of the care economy for increasing its investment into preventative initiatives. A dedicated fund would ensure sufficient and sustained financial resources to support actions aligned with the National Prevention Investment Framework and the broader National Preventive Health Strategy. It would also allow governments to make transparent progress toward national prevention spending goals and to rebalance the portfolio as evidence evolves, as seen in Victoria's EIIF and international practice.

Importantly, prevention should not be confined to the health and care sectors. The administration of the Fund should be guided by principles that promote nationally coordinated action across all policy domains, particularly those addressing the social determinants of health. For example, CHA continues to advocate for stronger integration of health and housing policy to support a resilient care workforce and address the growing number of older Australians falling through the cracks at the interface of housing, health, and aged care. Whole-of-government valuation tools (CBAx-style) and public, WSIPP-like benefit-cost libraries can make these cross-sector benefits visible at Budget time, strengthening incentives for joint investment.

Information request 3.2 (cont.)

What changes if any to the existing budget operational rules would be needed to support consideration of recommendations from the Prevention Framework Advisory Board?

Supporting the consideration of recommendations from the Prevention Framework Advisory Board (PFAB) would not require a wholesale rewrite of the Budget Process Operational Rules, but several targeted adjustments would be essential. First, a new gateway should be created in the New Policy Proposal (NPP) pathway so that any prevention-related proposal cannot proceed to Expenditure Review Committee (ERC) without the PFAB's advice. This would ensure that ERC decisions are informed by PFAB's comparative rankings, portfolio analysis, and economic assessments, rather than treating prevention bids as isolated initiatives. Second, the strict

requirement under Rule 2 that all NPPs worsening the underlying cash balance be fully offset over the forward estimates would need to be qualified. A narrow exception should be established for PFAB-endorsed prevention measures that demonstrate positive net present value or a benefit–cost ratio greater than one over a longer horizon, and which include credible evaluation and benefit-sharing arrangements. This would maintain fiscal discipline while recognising that many prevention payoffs occur across portfolios or beyond the four-year forward estimates.

The existing rules around cross-portfolio NPPs should also be strengthened by making cross-portfolio packaging the default for prevention programs, which almost always span health, housing, education, and justice. In addition, the performance and accountability framework that underpins the Budget should be updated to require prevention NPPs to align with *Measuring What Matters* and to report "lead and lag" indicators. Lead indicators such as uptake or fidelity would demonstrate early progress, while lag indicators would capture long-term health and fiscal outcomes. To improve comparability across portfolios, all prevention proposals should use a common valuation toolkit, akin to New Zealand Treasury's CBAx model or the UK Treasury's Green Book, so that ERC can weigh investments in health, housing, or education on the same terms.

Changes would also be needed to how intergovernmental funding is embedded. Under Rule 5.5, NPPs already require specification of deliverables for payments to states; for prevention, this should be expanded to require Federation Funding Agreement schedules with measurable outcomes, data-sharing, and benefit-sharing mechanisms so that jurisdictions are incentivised to co-invest. To support continuity, some prevention portfolios may need to be delivered through a standing appropriation or a dedicated special account, with disbursement rules guided by PFAB. This would reduce year-to-year "cliff" risks that undermine long-horizon prevention initiatives.

Existing risk and grant rules could also be better tailored to prevention. The Risk Potential Assessment Tool should remain in place, but funding gates should be tied to PFAB's lead/lag metrics so that programs are not cut prematurely. Likewise, the Commonwealth Grants Rules and Principles should explicitly incorporate PFAB-aligned merit criteria, such as equity and cross-sector benefits, when prevention programs are delivered through grant rounds, with rationale and assessments published transparently. Finally, ERC and Cabinet should be asked to consider not only the merits of individual proposals but also the overall balance of the prevention portfolio across sectors, time horizons, and levels of evidence maturity. In short, small but strategic edits to the BPORs, such as inserting PFAB into the NPP gateway, qualifying the offset rule, embedding cross-sector valuation, and requiring portfolio balance, would make the system fit to support prevention while retaining the fiscal discipline and accountability that underpin the Commonwealth budget process.

Information request 3.2 (cont.)

Should alternative approaches be considered for governance of the framework, including institutional setting, processes for arriving at co-funding arrangements, decisions and evidence requirements?

As previously noted, regardless of the chosen funding mechanism, formal joint arrangements between the Australian Government and state and territory governments are essential to ensure coordinated governance and implementation. CHA supports the continued use of existing processes for developing and administering federated funding arrangement schedules to facilitate payments from the Commonwealth to jurisdictions. However, the content and structure of these schedules should be enhanced to reflect the complexity and cross-sectoral nature of prevention initiatives. This should be done within the existing Federation Funding Agreements (FFA) architecture overseen by the Council on Federal Financial Relations (CFFR), which already provides principles, templates and a gatekeeper role for Commonwealth–state funding agreements.

To strengthen governance, CHA recommends that the development of these schedules involve a broad and representative group of stakeholders, including members of the Prevention Funding Advisory Board (PFAB), State and territory health ministers, and the federal Minister for Health, Disability and Ageing as a leading stakeholder. Two alternative institutional settings should be considered: (1) locating PFAB as an independent advisory body with secretariat support from the Department of the Treasury and Health, reporting through CFFR to embed whole-of-government oversight; or (2) establishing PFAB as a statutory advisory committee housed in Health but with a formal mandate to submit advice to CFFR and the Expenditure Review Committee for any prevention-related New Policy Proposals. Both options leverage existing intergovernmental machinery while keeping decisions anchored in fiscal/budget processes.

To support participation in joint funding arrangements, a transparent and evidence-informed tool should be developed to calculate expected co-contribution amounts from each party. This tool should be based on net future benefits and supported by clear data collection methodologies, supporting guidance on implementation and use, and clear alignment with existing funding and evaluation frameworks. International practice suggests adopting a CBAx-style, cross-government valuation toolkit to monetise outcomes consistently across sectors (health, education, justice, housing) so that benefit-sharing and co-contributions can be calculated on a comparable basis and embedded in FFA schedules. Where savings accrue to different jurisdictions or portfolios, schedules should include formula-based co-funding and periodic “true-ups,” administered under the FFA Framework.

The governance of the framework should be designed to integrate seamlessly with existing systems and processes, avoiding unnecessary administrative burden. Evidence and reporting requirements should be harmonised with current data collection practices, while also addressing known gaps in data and evaluation infrastructure. Evidence requirements should align with Australia’s *Measuring What Matters* wellbeing framework, linking prevention outcomes to nationally recognised wellbeing themes, and require both “lead” indicators (fidelity, uptake) and “lag” indicators (long-run health and fiscal outcomes) so programs with long horizons are not penalised. Public reporting can leverage existing infrastructure such as the National Preventive Health Monitoring Dashboard maintained by AIHW to provide transparent, comparable progress updates across jurisdictions.

In our submission to the Productivity Commission’s Inquiry, CHA proposed a Prevention Data and Digital Infrastructure Pilot. This initiative would establish an integrated data platform linking prevention programs with broader care economy datasets, including primary care, community services, and government-held performance indicators. The pilot would enable continuous outcome measurement, support real-time monitoring and predictive modelling, and have the capacity to trial advanced evaluation frameworks to quantify long-term and diffuse benefits of prevention. Importantly, this pilot would be aligned with existing policy frameworks, such as Measuring What Matters, to ensure coherence with national health and wellbeing agendas and support consistent decision-making across jurisdictions. As a practical governance option, the pilot could be referenced in FFA schedules and overseen by a small joint secretariat (Treasury/Health/AIHW), with data-sharing provisions and reporting cadences specified in the schedules, mirroring how other intergovernmental performance frameworks are operationalised. States can draw implementation lessons from Victoria’s Early Intervention Investment Framework, which integrates early-intervention logic into the Budget process and publishes tools/templates for consistent proposals and monitoring.

Decision processes should codify portfolio thinking: PFAB advice should include a portfolio view (sector/time-horizon/evidence-maturity mix) and be tabled with FFA schedules and Budget proposals, so governments balance quick wins with long-horizon prevention. Annual public “portfolio statements” would show allocations, expected benefit–cost ratios and distributional impacts, improving durability across electoral cycles.

Information request 3.2 (cont.)

What considerations would ensure that the framework works together with existing prevention programs funded by states and territories? How can the framework encourage governments to keep supporting existing effective prevention programs?

To ensure that a National Prevention Investment Framework complements and strengthens existing prevention programs funded by states and territories, several key considerations need to be addressed. The starting point is governance. Coordination should be anchored in the Federation Funding Agreements (FFA) Framework, which already provides the principles and mechanisms for Commonwealth–state financial relations. By embedding prevention measures within FFA schedules, governments can avoid duplicating processes and allow jurisdictions to incorporate their existing programs into a nationally consistent framework. This would enable local initiatives to remain intact while aligning on outcomes, data, and accountability.

Another essential consideration is the harmonisation of outcomes and indicators. States already collect and report a range of performance metrics, but these vary across sectors and programs. To reduce reporting burden and enhance comparability, the framework should align prevention outcomes with national priorities, particularly the National Preventive Health Strategy and Australia's wellbeing framework, Measuring What Matters. The AIHW National Preventive Health Monitoring Dashboard provides a ready-made vehicle for transparent and consistent reporting. Common indicators, such as rates of potentially preventable hospitalisations, would allow state-run primary care and community health initiatives to demonstrate their contribution to national health system performance. This approach would ensure that state programs report once and use the results across multiple levels of government.

Economic appraisal also plays a critical role in protecting and sustaining effective programs. A common valuation toolkit, such as a CBAx-style model, would allow interventions in health, housing, education, or justice to be compared on the same basis. This cross-sector comparability is important because many state-funded prevention programs generate benefits outside the health portfolio. If these benefits are consistently recognised at the Commonwealth level, states are more likely to continue supporting proven programs rather than redirecting funds to more visible acute care services.

Continuity of funding is equally important. Effective programs often risk termination when budget cycles change or when fiscal pressures mount. The framework should incorporate safeguards such as maintenance-of-effort and additionality clauses, which prevent Commonwealth contributions from replacing state dollars. Multi-year rolling appropriations and portfolio guardrails that set minimum funding shares for long-horizon initiatives and non-health sectors would further stabilise investment. Funding should also be structured around lead and lag indicators, with early measures of fidelity and uptake used to demonstrate progress, while long-term health and fiscal outcomes are allowed to mature. This balances accountability with durability.

Incentives for co-funding are another critical design feature. Prevention programs often generate fiscal savings in portfolios or jurisdictions other than those that bear the upfront costs. To address this, the framework should embed benefit-sharing and formula-based co-funding mechanisms within FFA schedules. Periodic "true-ups" based on updated evaluation evidence would allow costs and savings to be redistributed fairly over time, ensuring that all levels of government remain invested in sustaining effective programs.

Strengthening the evidence infrastructure will also be crucial. Rather than replacing state models, the framework should build on them. Victoria's Early Intervention Investment Framework (EIIF) demonstrates how budget proposals can be linked to quantifiable early-intervention impacts. By inviting states to adapt EIIF-style tools and datasets within the national framework, governments can enhance comparability while recognising local expertise. At a national level, publishing a

WSIPP-style library of comparable benefit–cost estimates would further highlight programs with strong long-run returns and help justify continued funding.

Finally, transparency will be a key enabler of sustained investment. A public dashboard that shows not only outcome indicators but also the composition of the prevention portfolio, by sector, time horizon, and evidence maturity, would keep attention on maintaining as well as launching initiatives. Building on existing AIHW reporting capacity, such a dashboard would allow decision makers and the public to see whether funding is balanced and whether proven programs are being preserved. In addition, durable state institutions such as VicHealth illustrate how long-term statutory funding models can maintain prevention capacity through electoral cycles. Integrating and supporting these types of state assets within the national framework, rather than duplicating them, would further encourage jurisdictions to keep investing in what already works.

In summary, a well-designed framework should function as a plug-and-play system with state and territory programs. By embedding initiatives in FFA schedules, harmonising indicators, adopting common valuation tools, securing continuity through portfolio rules, aligning incentives with benefit-sharing, and ensuring transparency through public dashboards, the framework would not only respect but also reinforce existing prevention efforts. This approach creates strong incentives for governments to sustain proven programs while still providing space to scale new initiatives, ultimately ensuring a balanced and durable prevention portfolio across Australia.

There are various frameworks that can be adapted to provide a basis for an investment framework that helps prioritise and plan for the implementation of public health proposals. Specific lessons learnt and key aspects of the following frameworks have been outlined in case studies below.

Case study: Strengthening Performance and Accountability Framework (ACT)

The ACT Government's Performance and Accountability Framework identifies performance measurement and accountability as two important but separate aspect of driving productivity and efficiencies with valuing new initiatives.

- **Performance measurement:** To assess whether investments (programs, services, initiatives) are achieving their intended objectives effectively and efficiently. This includes, but is not limited to: clear objectives, prioritisation of consistency and accuracy of measurement systems and data collection methods, optimisation of resource utilisation, monitoring and evaluation of outcomes and progress towards established objectives, and a clear feedback loop.
- **Accountability:** To ensure that individuals and organisations are answerable for their roles in achieving performance outcomes. Specific principles for consideration include the need for defined roles and responsibilities, proportional accountability, transparency and answerability, clear consideration of capacity, and a defined link to performance measurement.

This case study highlights the importance of embedding a robust performance and accountability framework to enable governments to justify continued investment in prevention programs, particularly from a budgetary resilience standpoint.

Case study: National Health and Climate Strategy Implementation Plan

The National Health and Climate Strategy Implementation Plan serves as a compelling example of how dedicated resourcing and structured governance can drive progress in prevention and future-readiness. Developed to operationalise the broader National Health and Climate Strategy, the Implementation Plan outlines specific actions mapped to clear timeframes, promoting transparency and accountability in delivery.

Central to its success is the leadership of the National Health, Sustainability and Climate Unit, a dedicated taskforce responsible for overseeing implementation. This model demonstrates the value of sustained investment in capability-building, ensuring that targeted actions are not only initiated but also maintained over time. By embedding prevention and climate resilience into the health system through a structured, resourced approach, the Plan exemplifies how governments can lead by example in advancing long-term health outcomes.

Case study: Victoria's Early Intervention Investment Framework (EIIF)

Victoria's Early Intervention Investment Framework (EIIF) was introduced to embed early intervention thinking directly into the state's budget process. Under the framework, agencies proposing new initiatives must demonstrate measurable early-intervention impacts using standardised templates and quantifiable indicators. The Department of Treasury and Finance oversees this process, linking proposals to forecast reductions in downstream service demand across health, justice, housing, and education. By integrating early-intervention appraisal into the budget cycle and publishing funded initiatives, the EIIF creates a transparent, evidence-based mechanism that prioritises prevention and secures multi-year funding commitments. This case study highlights the value of structuring investment decisions around measurable early impacts to build long-term fiscal resilience.