Australian Government
Productivity Commission

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Delivering quality care more efficiently

Interim report

This is an interim report prepared for further public consultation and input. The PC will finalise its report after these processes have taken place.

August 2025

The Productivity Commission acknowledges the Traditional Owners of Country throughout Australia and their continuing connection to land, waters and community. We pay our respects to their Cultures, Country and Elders past and present.

The Productivity Commission

The Productivity Commission (PC) is the Australian Government's independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians. Its role, expressed most simply, is to help governments make better policies, in the long-term interest of the Australian community.

The PC's independence is underpinned by an Act of Parliament. Its processes and outputs are open to public scrutiny and are driven by concern for the wellbeing of the community as a whole.

For more information, visit the PC's website: www.pc.gov.au

An appropriate reference for this publication is:
Productivity Commission 2025, *Delivering quality care more efficiently*, Interim report, Canberra, August.

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Opportunity for comment

The PC thanks all participants for their contribution to this inquiry and now seeks additional input for the final report.

You are invited to examine this interim report and comment on it by written submission to the PC, preferably in electronic format, by 15 September 2025.

Further information on how to provide a submission is included on the website: www.pc.gov.au/inquiries/current/quality-care

The PC will prepare the final report after further submissions have been received, and it will hold further discussions with participants.

Commissioners

Alison Roberts	Commissioner
Martin Stokie	Commissioner
Angela Jackson	Commissioner

Terms of reference

I, Jim Chalmers, pursuant to Parts 2 and 3 of the *Productivity Commission Act 1998*, hereby request that the Productivity Commission ("the Commission") undertake five inquiries to identify priority reforms under each of the five pillars of the Government's productivity growth agenda and formulate actionable recommendations to assist governments to make meaningful and measurable productivity-enhancing reforms.

Background

Productivity growth is the key driver of real wage growth and rising living standards over the long term but has been slowing around the world since the mid-2000s. Australia's productivity growth in the decade to 2020 was the slowest in 60 years.

Several long-standing factors have contributed to the productivity slowdown, including reduced dynamism and competitive pressures, and slower diffusion of technological innovations. Australia also faces new and emerging opportunities and challenges from the changing nature of our economy, including population ageing, rising demand for care and support services, technological and digital transformation, climate change and the net zero transformation, and geopolitical risk and fragmentation. How well we position for and respond to these changes will have a significant impact on our future productivity.

In 2023, the Government set out five pillars for a broad and ambitious productivity growth agenda, and it has already progressed significant reforms under each pillar of this agenda. It is now tasking the Productivity Commission to identify the highest priority reform areas under each of the five pillars which have potential to materially boost Australia's productivity growth going forward, and the measurable impact of these reforms where possible.

Scope of the inquiries

The Commission will conduct five inquiries to identify and report on priority reforms in each of the areas under the Government's five pillar productivity growth agenda. Specifically, these are priority reforms which enhance productivity through:

a. Creating a more dynamic and resilient economy
b. Building a skilled and adaptable workforce
c. Harnessing data and digital technology
d. Delivering quality care more efficiently
e. Investing in cheaper, cleaner energy and the net zero transformation

The Commission should have regard to other current and recent reviews of relevance to Australia's productivity performance including the Treasury Competition Taskforce, the National Competition Review and the House Economics Committee inquiry into promoting economic dynamism, competition and business formation; and the objectives and priorities outlined in the Intergenerational Report, the Employment White Paper, the Economic and Fiscal Strategy, the Measuring What Matters statement, and the Government's legislated emissions reduction targets.

The inquiries should identify prospective areas for reform in the coming years, recognising the findings of recent reviews and taking into account Government reforms and reform directions.

Process

The Commission should engage widely and undertake appropriate public consultation processes, including inviting public submissions. The Commission should engage actively with Commonwealth, and state and territory governments.

The Commission's advice should clearly convey the importance of the reform opportunities identified, including quantitative analysis of the measurable benefits of the priority reforms where possible. This could include the long-run economic impacts on GDP and other measures of economic progress and national prosperity, the benefits accruing to Australian households including distributional impacts where possible, or other outcomes such as improved quality of services or living standards. This analysis should be presented in a way which acknowledges and manages the measurement challenges impacting some important reform areas.

The Commission should publish an interim report for each inquiry in the middle of 2025 that includes preliminary actionable recommendations for productivity-enhancing reforms under the relevant pillar. The final reports for these inquiries should include advice on reform implementation, including implementation feasibility and risks, and be provided to Government within 12 months of receipt of this request.

The Hon Jim Chalmers MP
Treasurer

[Received 13 December 2024]

Disclosure of interests

The *Productivity Commission Act 1998* specifies that where Commissioners have or acquire interests, pecuniary or otherwise, that could conflict with the proper performance of their functions they must disclose those interests.

Commissioner Dr Angela Jackson is Chair of the National Committee of the Women in Economics Network, Adjunct Associate Professor at the University of Tasmania and was previously a non-Executive Director of Melbourne Health.

Commissioner Martin Stokie and Commissioner Dr Alison Roberts have no interests requiring disclosure.

Acknowledgments

The Commissioners express their appreciation to the staff who worked on the interim report – Assistant Commissioner Catie Bradbear, who leads the inquiry, and other team members including Archana Subramaniam, Billy Morton, Cordelia Buntsma, Cristy Alevizos, Daniel McDonald, Imogen Jameson, Luc Borrowman, Matt Forbes, Nicholas Sladden, Sasha Zegenhagen, Tim Griffin and Vanessa Boltman. Our thanks are also extended to Yvette Goss and Tracey Horsfall for administrative and project support.

Contents

Executive summary

High quality care services – across health care, early childhood education and care, disability support, aged care, veterans' care and other community services – enable us to live independent lives and participate more fully in the community and economy. Over recent decades, choice in services has increased and quality of care has improved. New and more innovative ways of delivering care have been introduced. But as the population and its needs continue to change, the care system is coming under increasing pressure to deliver high-quality services at a sustainable cost.

Governments can shape the trajectory of the care economy through reforms that enhance the connections between sectors and break through the siloed approach to government decision making. This will improve the quality of care services and make their delivery more efficient. We outline three such opportunities to boost productivity in the care economy in this report.

First, greater alignment of safety and quality regulation in the care economy is needed. Regulation is essential for protecting people's rights and safety, but taking different approaches across sectors creates risks and reduces choice for care users and leads to unnecessary costs for care workers and providers.

We propose the Australian Government pursue greater alignment in quality and safety regulation across care sectors, including developing a standardised safety and quality reporting framework and data repository, and introducing a single set of practice and quality standards for aged care and National Disability Insurance Scheme services. Getting these regulatory settings right will improve workers' mobility, enable providers to redirect resources into frontline services and provide care users with better information to support choice. A joined-up approach will also better protect care users from unsafe providers and workers.

Second, governments should embed the practice of organisations working in partnership to plan, procure and evaluate services for their local communities. This practice, known as collaborative commissioning, has potential to support more integrated care, address service gaps and tailor care services to local needs.

While collaborative commissioning is endorsed in government plans and agreements, this ambition remains unrealised. As a start, governance arrangements between Local Hospital Networks, Primary Health Networks and Aboriginal Community Controlled Health Organisations should be strengthened to support more collaboration. Greater flexibility to address local needs and dedicated funding for more integrated care, including initiatives that minimise potentially preventable hospitalisations, are also required, to enhance productivity and lower potential future costs.

Finally, a new approach to prevention investment is needed, through a National Prevention Investment Framework. Stopping problems from starting or getting worse – particularly for vulnerable populations – can result in better outcomes for individuals and the community. Investing in effective prevention can reduce demand for acute and more costly services down the track, helping to slow ongoing growth in government expenditure. The proposed framework will support a different approach to government investment in prevention by recognising that the benefits fall across sectors and levels of government, and over extended timeframes. At the centre of the framework is a new national independent advisory board that would evaluate ongoing prevention programs and assess the cost-effectiveness of new programs. Where programs involve the states and territories, they should contribute funding based on their expected proportional benefit.

Draft recommendations

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

Draft recommendation 1.1
The Australian Government should pursue greater alignment in quality and safety regulation of the care economy to improve efficiency and outcomes for care users

The Australian Government should pursue greater alignment in quality and safety regulation of the care economy, initially focusing on the aged care, National Disability Insurance Scheme (NDIS) and veterans' care sectors. As a first step towards achieving this goal, the Australian Government should implement the following suite of actions.

- To align **care worker** regulation**,** the Australian Government should, within three years:
  - develop a national screening clearance for workers in the aged care, NDIS, veterans' care and early childhood education and care (ECEC) sectors in collaboration with state and territory governments
  - adopt a unified approach to worker registration across the aged care, NDIS and veterans' care sectors, supported by:
    - a national registration system and single portal for workers required to be registered
    - mutual recognition arrangements for health workers already registered through the National Registration and Accreditation Scheme.
- To align the approach taken to **care provider accreditation, registration and audits,** the Australian Government should:
  - within three years:
    - establish a common suitability assessment for providers operating across the aged care, NDIS, veterans' care and ECEC sectors
    - establish mutual recognition of audits against the aged care quality standards and NDIS practice standards
    - create a single digital portal for providers to manage their registration and audits across the aged care, NDIS and veterans' care sectors
  - within a further three years:
    - create a single (potentially modular) set of practice and quality standards across aged care and NDIS services
    - develop a cross-sectoral registration system for registered providers across the aged care, NDIS and veterans' care sectors.
- To align the **broader regulatory landscape**, the Australian Government should:
  - ensure a consistent approach to the regulation of artificial intelligence across the aged care, NDIS and veterans' care sectors (within three years)

Draft recommendation 1.1
The Australian Government should pursue greater alignment in quality and safety regulation of the care economy to improve efficiency and outcomes for care users

- establish a standardised quality and safety reporting framework and data repository to hold data reported against the framework, which could also be used to more consistently measure productivity and report on performance across sectors (within three years)
- explore the suitability of a single regulator across the aged care, NDIS and veterans' care sectors (within six years)
- in collaboration with state and territory governments, explore the potential for greater alignment in the regulation of behaviour support plans and use of restrictive practices focusing on the aged care and NDIS sectors, and implement agreed actions (within six years).

Embed collaborative commissioning to increase the integration of care services

Draft recommendation 2.1
Governments should embed collaborative commissioning, with an initial focus on reducing fragmentation in health care to foster innovation, improve care outcomes and generate savings

In the next addendum to the *National Health Reform Agreement*, governments should agree to governance and funding arrangements that support better collaboration between Local Hospital Networks (LHNs), Primary Health Networks (PHNs) and Aboriginal Community Controlled Health Organisations (ACCHOs).

New joint governance arrangements to support collaboration are needed.

- LHNs and PHNs should be required to plan together to identify areas for collaboration, including joint needs assessments, agreed plans of work and joint monitoring and reporting of outcomes.
- LHNs and PHNs must work in partnership with ACCHOs and other organisations to inform planning and shared decision making. Partnering with ACCHOs should be consistent with the principles set out in the National Agreement on Closing the Gap to ensure relevant needs are appropriately and respectfully assessed and key decisions are shared.
- There needs to be stronger requirements for formal joint collaborative commissioning committees and the development of data-sharing arrangements to underpin joint needs assessments and evaluation of outcomes.

Changes to funding arrangements are also needed to embed collaborative commissioning.

- Barriers to pooling funding or other forms of joint commissioning should be removed. The Australian Government should make funding for PHNs more flexible. State and territory governments need to ensure that service agreements provide flexibility in the services and programs that LHNs can fund.
- LHNs, PHNs and ACCHOs should be sufficiently resourced to undertake comprehensive joint governance.

Draft recommendation 2.1
Governments should embed collaborative commissioning, with an initial focus on reducing fragmentation in health care to foster innovation, improve care outcomes and generate savings

- The Australian Government should provide LHNs and PHNs with sufficient dedicated funding to embed collaborative commissioning programs once they submit a joint plan. The joint plan should clearly link agreed shared outcomes to enhanced productivity in the form of quality improvements or more services that lower potential future costs. Initially, the focus should be on reducing potentially preventable hospitalisations. Future funding should be adjusted based on whether agreed shared outcomes have been achieved at the local level.

A national framework to support government investment in prevention

Draft recommendation 3.1
Establish a National Prevention Investment Framework to support investment in prevention, improving outcomes and slowing the escalating growth in government care expenditure

The Australian Government should work with state and territory governments to establish a National Prevention Investment Framework. The framework will support governments to invest in prevention programs that improve outcomes and reduce demand for future acute care services. It will identify programs that produce the best value for money, based on rigorous assessment and evaluation. The framework should provide a stable and ongoing basis for funding prevention, recognising that the benefits fall across sectors and levels of government, and over extended timeframes.

The framework should be implemented by establishing:

- an independent Prevention Framework Advisory Board that assesses and provides expert advice on requests for prevention funding and develops a standardised actuarial model and frameworks for the analysis of prevention programs. The board would evaluate ongoing prevention programs, recommend whether programs should continue to be funded, and build the evidence base for prevention
- a funding mechanism that supports eligible prevention initiatives across Australian, state and territory governments. The mechanism should support co-contributions from state and territory governments based on their expected benefits, enable consideration of the second-round and longer-term fiscal effects of prevention programs, and facilitate ongoing funding where needed
- an intergovernmental agreement between the Australian, state and territory governments that outlines prevention funding arrangements and the roles and responsibilities of relevant parties. The agreement should be accompanied by federation funding agreement schedules that deliver Australian Government funding to states and territories for specific interventions.

About this inquiry

Care is central to our lives and the economy

At its heart, care is a human interaction that supports wellbeing, dignity and an active life for all Australians (figure 1). Care services such as health care, early childhood education and care, aged care, disability support and veterans' care[1] have many benefits. They can improve the physical and mental health of those who receive them and enable greater participation in the community and the economy. For example, access to early childhood education and care and aged care services can boost the workforce participation of parents and care givers. A healthier population has higher labour force participation and productivity, with lower unemployment and absenteeism (PC 2017b, pp. 14–15). Care services also provide support for vulnerable people in our community, reducing disadvantage and delivering improved health, wellbeing and social inclusion outcomes (PC 2018).

Figure 1 – Many Australians use formal care services

Source: AIHW (2024c); NACCHO (2025); NDIA (2025c, p. 17); SCRGSP (2025b, 2025a).

The care economy is large and growing

The care economy is complex, involving multiple funding systems, quasi-markets and a mix of government, private and not-for-profit providers. It is one of the largest parts of the Australian economy, with more than 2 million people employed in care-related roles (ABS 2025a). Women comprise 79% of the care and support workforce (NSC 2021b, p. 95).

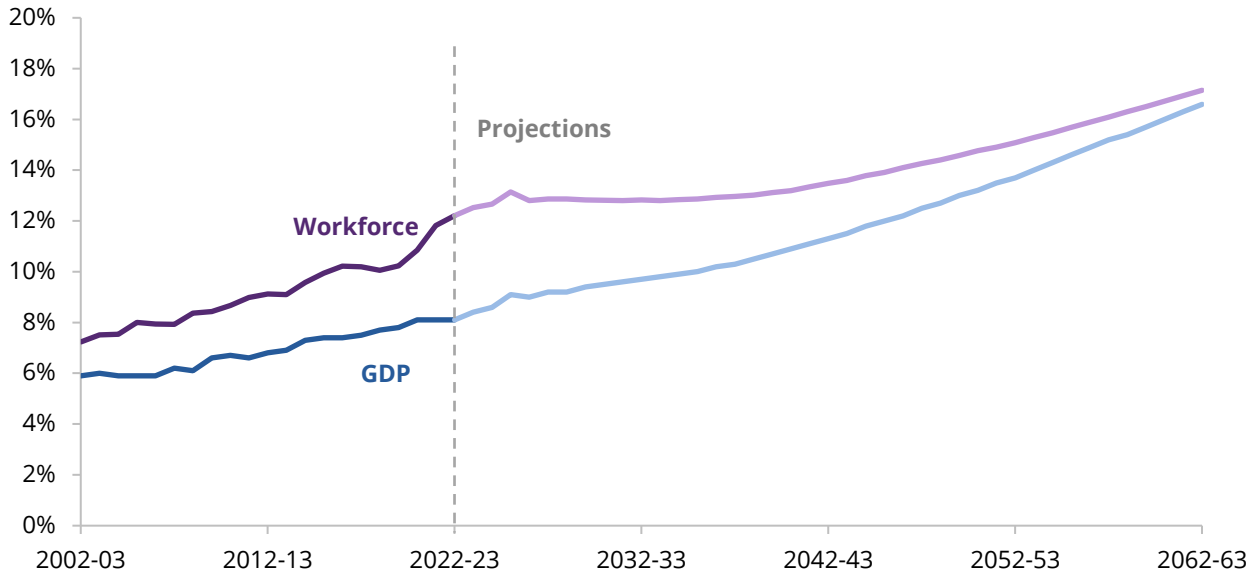
There is also a significant number of informal carers, with women undertaking two-thirds of primary care-giving (ABS 2022). For some Aboriginal and Torres Strait Islander people, care responsibilities may be undertaken by extended kinship and community networks (Salmon et al. 2019).

[1] Some reforms in this inquiry will also affect areas like education, housing, family services and justice services – sectors not usually considered part of the care economy but closely linked to its outcomes.

The care economy is growing fast, having more than doubled its workforce over the 20 years to 2020 (NSC 2021a). It contributed 8% of Australia's GDP, and an estimated 12% of the workforce in 2022-23 (Commonwealth of Australia 2023a, p. 16). Both shares are expected to grow over the next 40 years (figure 2).

Figure 2 – The care economy will continue to grow

Care economy as a percentage of GDP and the workforce[a]



a. Commonwealth of Australia (2023a) data based on the Australian Bureau of Statistics' Australian and New Zealand Industrial Classification for the Health Care and Social Assistance Division, which uses Gross Value Added (GVA) to represent total output.

Source: PC estimates based on Commonwealth of Australia (2023) data.

This trend is not unique to Australia and is driven by several factors. In particular, an ageing population is causing a rise in chronic illnesses and demand for health and aged care services (Commonwealth of Australia 2023a, p. 146). Further, as societies become wealthier, they tend to spend a larger share of income on services that enhance quality of life. This has coincided with a move to more formal care arrangements that reflect changing social norms (Commonwealth of Australia 2023a, p. 15). For example, the expansion in early childhood education and care services and rollout of the National Disability Insurance Scheme (NDIS) have occurred alongside an increase in female workforce participation for those aged 15 years and over, from about 45% in 1984 to about 63% in 2025 (ABS 2025c).

The productivity challenge

Improving productivity in the care economy is challenging because of the fundamental human nature of care. Delivering more services per care giver is difficult without also constraining the personal interactions that are essential to the care we value. As such, much of the scope for improved productivity in the care economy lies in delivering better quality care that leads to better outcomes.

Quality, however, is not captured in traditional approaches to measuring productivity. For example, multifactor productivity in the hospital sector grew on average by just 0.1% per year between 2008-09 and 2018-19 (ABS 2021), below the average of 0.7% growth per year in the market sector (PC 2024a). Yet, over time, the quality of some care and associated patient outcomes has improved significantly. For example, cancer treatments are far more effective in 2024 than in 1995 (AIHW 2024a).

When quality is considered, productivity growth can look quite different. For example, when adjusted for quality, productivity growth for a subset of the healthcare sector – accounting for about one third of healthcare spending – actually outpaced the broader economy, growing by about 3% per year between 2011-12 and 2017-18 (PC 2024a).

While there may have been productivity improvements in the form of better outcomes, the care economy continues to grapple with rising costs. In other sectors, productivity gains can reduce the cost of producing goods or services, supporting higher wages. In the care economy, wages must rise to attract and retain workers, but it does not experience the same reduction in costs from higher productivity. Higher wages and the care economy being relatively more labour-intensive, means that costs rise faster than in other sectors, a phenomenon known as Baumol's cost disease.

Simply put, Australians are getting better outcomes, but not necessarily more care services, per dollar spent.

New technologies, however, offer scope to unleash large gains to labour productivity while also improving quality of care and lowering costs. AI scribes can reduce time workers spend on reporting, while robots can perform routine tasks such as vitals monitoring and logistics. Scaling these technologies could free workers to focus more on high-value, face-to-face care. To harness these opportunities, governments must ensure that regulatory settings support innovation while managing its risks.

The focus of this inquiry

Inquiry participants from government, industry, academia, service providers and the community shared a wide range of ideas for improving productivity in the care economy. These included supporting more efficient models of care, changing the structure of payments for providers, reducing the need for acute care, making smarter use of the workforce and harnessing data and digital technologies.

This inquiry could not tackle all these suggestions. In some cases, other work is underway and we are mindful that this inquiry comes at a time of significant change in some care sectors, including from responses to the *Royal Commission into Aged Care Quality and Safety*, the *Independent review into the NDIS* and the PC's inquiry into early childhood education and care.

We have instead applied a lens to reforms that will enhance the connections between care sectors and break through the current siloed approach to government decision-making. The fragmented nature of the care economy was a common theme through our engagement. The care economy must be able to respond to our increasingly complex and overlapping care needs, often spanning multiple sectors. We have identified three opportunities for reform that will move the care economy in this direction. Governments should:

- reform quality and safety regulation to support a more cohesive care economy (chapter 1)
- embed collaborative commissioning to create more integrated care services (chapter 2)
- establish a national framework to support investment in prevention (chapter 3).

These reforms cut across care sectors but operate within different levels of the system. Regulatory reform concerns care users, workers and providers and is at the micro-level; collaborative commissioning involves organisation-level change at the meso-level; and the national prevention framework concerns reforming government-decision making at the macro-level.

The reforms we outline are not a cure-all for improving productivity in the care economy. But they are a significant step towards a care economy that delivers better quality services for care users while operating more efficiently.

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

Summary

- **Regulation is an essential part of the care economy, protecting against unsafe and poor-quality care and providing valuable indicators of service quality to drive better outcomes. However, fragmented and misaligned regulation across different care sectors and services creates unnecessary burden and costs for care users, providers, workers and government, reducing the productivity of the sector. There is a need to remove unnecessary complexities and costs while protecting the rights and safety of care users and ensuring regulation remains fit for purpose.**

- **Previous endeavours to align regulation have faced roadblocks and lost momentum. A fresh, concerted effort is needed across care sectors to support a more cohesive care economy. The Productivity Commission's vision is for a quality and safety regulatory system that is aligned across all care sectors and levels of government, and is consistent with the principles of leading-practice regulation.**

- **As a first step, the PC proposes immediate actions for the next three years, along with longer-term actions over the next six years.**
  - These actions focus on the aged care, National Disability Insurance Scheme (NDIS) and veterans' care sectors. However, many of the proposed actions are also relevant to other care sectors or can be extended to them over time. The immediate actions are primarily about streamlining processes for providers and workers, while the longer-term actions seek to achieve more fundamental alignment in regulatory systems.

- **To successfully implement our recommendation, governments need to stay the course. Recent changes to combine the Commonwealth aged care and disability portfolios should make the task of regulatory alignment easier, but the Australian Government will still have to articulate the vision, demonstrate leadership and create an enabling environment to drive reform over the next six years and beyond.**

Draft recommendation

Draft recommendation 1.1
The Australian Government should pursue greater alignment in quality and safety regulation of the care economy to improve efficiency and outcomes for care users

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- To align **care worker** regulation**,** the Australian Government should, within three years:
  - develop a national screening clearance for workers in the aged care, NDIS, veterans' care and early childhood education and care (ECEC) sectors in collaboration with state and territory governments
  - adopt a unified approach to worker registration across the aged care, NDIS and veterans' care sectors, supported by:
    - a national registration system and single portal for workers required to be registered
    - mutual recognition arrangements for health workers already registered through the National Registration and Accreditation Scheme.
- To align the approach taken to **care provider accreditation, registration and audits,** the Australian Government should:
  - within three years:
    - establish a common suitability assessment for providers operating across the aged care, NDIS, veterans' care and ECEC sectors
    - establish mutual recognition of audits against the aged care quality standards and NDIS practice standards
    - create a single digital portal for providers to manage their registration and audits across the aged care, NDIS and veterans' care sectors
  - within a further three years:
    - create a single (potentially modular) set of practice and quality standards across aged care and NDIS services
    - develop a cross-sectoral registration system for registered providers across the aged care, NDIS and veterans' care sectors.
- To align the **broader regulatory landscape**, the Australian Government should:
  - ensure a consistent approach to the regulation of artificial intelligence across the aged care, NDIS and veterans' care sectors (within three years)
  - establish a standardised quality and safety reporting framework and data repository to hold data reported against the framework, which could also be used to more consistently measure productivity and report on performance across sectors (within three years)
  - explore the suitability of a single regulator across the aged care, NDIS and veterans' care sectors (within six years)
  - in collaboration with state and territory governments, explore the potential for greater alignment in the regulation of behaviour support plans and use of restrictive practices focusing on the aged care and NDIS sectors, and implement agreed actions (within six years).

A more cohesive regulatory framework would improve care and its efficiency

Quality and safety regulation is fragmented

Quality and safety regulation is a vital foundation of the care economy, making providers accountable, reducing harm, driving improvement in outcomes, and setting minimum standards to ensure that care users are treated with dignity, fairness and respect. Care users may not always be able to advocate for themselves or assess the quality of the services they receive, so strong regulatory oversight is vital to protect their rights and safeguard against neglect, abuse and poor-quality care. Information gathered through regulatory activities also provides valuable indicators of service quality, helping care users make informed choices and rewarding providers that offer high-quality services.

Quality and safety in the care economy is regulated through various mechanisms across multiple levels of government. In sectors such as early childhood education and care (ECEC), aged care and the National Disability Insurance Scheme (NDIS), legislation sets out minimum quality and safety standards. In health care, standards are developed by the Australian Commission on Safety and Quality in Health Care in collaboration with relevant stakeholders, and state and territory legislation mandate their implementation. In veterans' care and other health and social services, service agreements or contracts specify quality and safety requirements. Quality and safety can also be influenced by professional regulations and standards, including registration and licensing schemes applying to health and care workers. And workplace health and safety regulations can also apply, which set out what health and safety risks must be managed and who is responsible for managing them.

Collectively, these regulatory layers shape how care is delivered, but they also create complexity. Providers and users must navigate a fragmented system that varies across care sectors. In recent years, significant regulatory reforms have also been introduced, particularly in response to the findings of royal commissions and reviews in the aged care and NDIS sectors (figure 1.1).[2] While these reforms have aimed to address serious harms and risks, they have also added layers to an already complex system. New regulations in one sector have often been developed in isolation and have not always aligned with those in others, adding to duplication and inconsistent standards. This fragmented landscape has made it harder for providers and workers to operate across different sectors and for care users to understand what they can expect from services in each sector.

The costs of fragmented regulation

Ultimately, care users bear the consequences of fragmented regulation through difficulties in accessing care or navigating the system, receiving low-quality care, or shouldering the risks of poorly coordinated action. However, providers, workers and governments can also be affected, for example through time spent doing duplicative paperwork, which directs care staff away from service delivery and reduces the productivity of the sector. The goal should be to eliminate these unnecessary costs while ensuring users receive safe, high-quality care.

[2] There have also been reviews relating to other care sectors, such as the *Royal Commission into Defence and Veteran Suicide* and the PC's inquiry into the ECEC sector, which both concluded in 2024. In recent months, governments have also committed to reforms to strengthen safety in ECEC, including by introducing state-based and national childcare worker registers (Kolovos 2025).

Figure 1.1 – Recent reviews and royal commissions have exposed regulatory failings within the aged care and disability sectors[a]

Royal Commission into Aged Care Quality and Safety	Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability	Joint standing committee on the NDIS – inquiry into the NDIS Quality and Safeguards Commission
October 2018 – February 2021 • Found the regulatory framework was fragmented, complex and lacking effective oversight • Recommended a new rights-based Aged Care Act • Called for the establishment of independent authorities to oversee quality and safety • Recommended more rigorous accreditation standards • Advocated for mandatory reporting of serious incidents	**April 2019 – September 2023** • Found a fragmented regulatory landscape, insufficient oversight and inadequate resources • Identified a need for independent oversight and stronger mandatory reporting and safeguards	**June 2020 – November 2021** • Found that the NDIS regulatory environment is overly complex, with unclear roles • Highlighted the lack of effective regulation in managing the NDIS market • Raised concerns about inadequate regulatory safeguards for participants
Independent review into the NDIS	**NDIS review: Building a more responsive and supportive workforce**	**NDIS provider and worker registration taskforce**
October 2022 – October 2023 • Found the regulatory framework was fragmented, lacking coherence across jurisdictions • Recommended a graduated, risk-based approach to regulating all providers and workers • Emphasised the need for regulatory changes that promote equity, inclusion and access	**May 2023** • Found that inconsistent workforce regulation across the care sector made it difficult to manage workforce quality and mobility • Recommended streamlining worker screening to reduce barriers to entry • Called for better regulation of training standards and clearer career pathways	**August 2024** • Supported applying the NDIS review's graduated, risk-proportionate registration and enrolment framework to most providers • Found the NDIS worker screening process was hindered by a lack of national consistency and difficulties in information sharing between jurisdictions

a. The recommendations of the *Royal Commission into Defence and Veteran Suicide*, which concluded in 2024, did not include reforming the regulation of care services, which is the focus of this inquiry.

Source: Commonwealth of Australia (2021c, 2021b, 2023c, 2023d, 2023b); Wade et al. (2024).

For providers, the costs of duplication in compliance and administration can add up quickly. One provider told us it was required to complete 15 separate accreditation processes across its health and social care services. Another, the Benevolent Society (qr. 73, p. 1), said it was accountable to over 350 pieces of legislation and regulations and a minimum of 16 program audits every three years, often requiring it to produce the same information over and over. One community health organisation, Better Health Network,

estimated that its seven accreditation and associated audit processes, which often required identical evidence, cost around $150,000 to $200,000 per year (pers. comm., 8 July 2025).

High administrative costs, both in terms of time and money, can mean providers withdraw some services or choose not to expand into new service areas, reducing availability and choice for care users, especially in thin markets. Providers may also need to employ specialised compliance personnel or direct frontline staff away from service delivery towards these administrative tasks, creating risks to quality care and access.

> Programs subject to mandatory accreditation must undergo audits every 18 months, placing a considerable burden on frontline and managerial staff who are often in a near-constant state of audit preparation. (The Benevolent Society, qr. 73, p. 1)

> Many [Catholic Health Australia] members operate across multiple states and are subject to different reporting requirements or clinical safety mandates depending on location. These members must reconcile the expectations of various regulators and accreditation bodies, creating inefficiencies and diverting resources away from direct patient care. (CHA, qr. 65, p. 1)

> Our partners also report that their current focus on compliance and meeting significant regulatory reform agendas has severely limited their opportunity to participate in research, development and innovation activities. This is a significant concern as innovation is required to improve future care outcomes and ensure service delivery is best-practice and contemporary. (Care Economy CRC, qr. 51, p. 1)

Duplicative, fragmented and inefficient regulatory arrangements also have a cost to care workers, most of whom are women. Workers may be required to undergo separate screening processes for each sector or program they work in, even though the types of checks undertaken overlap significantly. Effective worker screening is needed to protect the most vulnerable in our community and standards should be set at a level that enables this. But fragmented systems across care sectors and jurisdictions can mean unsafe workers slip through the cracks unnoticed, undermining the integrity of the screening process and putting care users at risk. Unnecessary duplication and inefficiencies in processes can also mean workers are required to pay for multiple checks or experience delays that lead to lost income or missed employment opportunities.

For care users, on top of reduced choice and accessibility, differences in regulation and multiple access points for information can make it difficult to navigate and compare the services that *are* available. Like providers and workers, care users must spend time and energy understanding different systems and services.

> Patients with complex or chronic conditions often find themselves navigating a fragmented system, where differences in regulatory frameworks hinder coordination and integration of services. (CHA, qr. 65, p. 1)

> For people needing support from multiple systems – such as aged care, disability, and health – these regulatory inconsistencies can lead to confusion, delays, and fragmented care. (Margo Linn Barr, qr. 35, p. 2)

> For veterans, regulatory inconsistencies can result in gaps in care, duplication of processes, and confusion about service entitlements – making it more complex and costly to access timely, coordinated care. (Julie Thorpe, qr. 40, p. 2)

Further, misaligned standards and reporting requirements also mean that information governments publish on service quality, if available at all, cannot be compared across services. This limits users' ability to choose high-quality services that best meet their needs, which dampens incentives for providers to improve quality.

Finally, a disjointed regulatory system costs more and can make it difficult for governments to effectively oversee the care economy as a whole. The need to operate separate regulatory regimes and agencies, each

with their own systems and processes, increases the costs of running the system. It also increases the costs of acting in a coordinated manner, since the information government needs to regulate well is spread across different parts of the system. Higher costs to run the system mean governments' care budgets cannot stretch as far (all else equal), and those who need care must wait longer, miss out or receive a lower-quality service.

Regulation needs to be better aligned

A more cohesive approach to quality and safety regulation across care sectors would improve outcomes for care users, while also reducing the costs outlined above. Creating a more aligned regulatory system is also consistent with regulators and policymakers acting as effective regulatory stewards, as outlined in the PC's inquiry into *Creating a more dynamic and resilient economy* (PC 2025b).

A number of questionnaire respondents supported greater alignment in quality and safety regulation across care sectors.

> Consistent processes across States and Commonwealth and different sectors such as aged care and disability will reduce inefficiencies and duplication of effort and improve the quality of care/support and the standard of practi[c]e. It will also create better understanding of legislative and compliance responsibilities by providers and allow for increased mobility of workforce. (Scope (Aust) Ltd, qr. 27, p. 2)

> Alignment of regulations would enable greater consistency in the standard of care delivered across the country, regardless of whether a person is accessing services in hospital, primary care, aged care, or community care … When different parts of the system operate under incompatible safety requirements, reporting mechanisms, and service standards, care can become disjointed, and the risk of harm increases. Regulatory alignment would support smoother transitions of care and better continuity, reducing the likelihood of duplication, gaps, or delays. (CHA, qr. 65, p. 2)

> Significant benefits for Aboriginal and Torres Strait Islander people can be gained from a single set of aged, disability and veterans' care regulations. Consolidated regulations should align with the priorities of the National Agreement for Closing the Gap (National Agreement), and should be streamlined across jurisdictions. (NACCHO, sub. 32, p. 8)

Importantly, a more cohesive approach does not necessarily mean complete harmonisation in situations where there are specific differences between care sectors. As noted by questionnaire respondents, differences across sectors can justify tailored approaches to regulation in certain circumstances.

> We encourage regulatory and quality alignment across the different care service types at every possible opportunity although acknowledge the need for differences in context-specific approaches critical to safety and quality for each service type. (Care economy CRC, qr. 51, p. 2)

> … there must be opportunities for a nuanced approach that enables the differences between service sectors and care recipient groups to be appropriately addressed, however we also believe that streamlining regulation across all parts of the direct care and support sector will have a positive impact for all Australians who require care, and the family and friend carers who support them. (Carers NSW, qr. 78, p. 2)

The PC's goal is to remove unnecessary complexity and cost for care users, providers, workers and government, while protecting the rights and safety of care users and ensuring regulation remains fit for purpose. Current differences in regulation go beyond what is justified by the differences across sectors, meaning that there is real scope to streamline regulation without sacrificing outcomes (and indeed while improving outcomes in some cases).

The need for greater alignment is not new. Several initiatives in recent years have sought to better align regulation, particularly across care sectors funded and regulated by the Australian Government (box 1.1). However, these efforts have lost momentum, and a renewed and sustained commitment to reduce fragmentation and pursue efficiencies is needed, with the goal of improving care outcomes. Our recommendation seeks to catalyse that commitment and provide a pathway to long-term progress.

Box 1.1 – Regulatory alignment has been pursued before

In 2021, a regulatory alignment taskforce was established within the Department of Health (now the Department of Health, Disability and Ageing). The Budget provided $12.3 million over two years to increase information sharing between regulators, align auditing arrangements and compliance and enforcement powers, review the NDIS Quality and Safeguards Framework and consult with the sector about options for further reform to align regulation and safeguards (Commonwealth of Australia 2021a, p. 178). The taskforce published several background and consultation papers on regulatory alignment, consulted with stakeholders and summarised their views (DoH 2021b, 2021a, 2022) and developed an aged care code of conduct.

In late 2022, a care and support economy taskforce was established within the Department of the Prime Minister and Cabinet. The taskforce developed a draft Care and Support Economy Strategy (PMC 2023), which included addressing regulatory duplication, burden and rigidity, and reducing the burden of reporting. Following the conclusion of the taskforce in June 2024, the Care and Support Reform Unit was created in the department to support, track and advise on the alignment of reforms across the care and support economy (PMC 2024).

Towards greater regulatory alignment

The PC's vision is for a quality and safety regulatory system that is aligned across all care sectors, levels of government and forms of regulation, consistent with principles of leading-practice regulation, which require that regulation not be overly complex, duplication is avoided and administrative costs are no higher than necessary (figure 1.2).

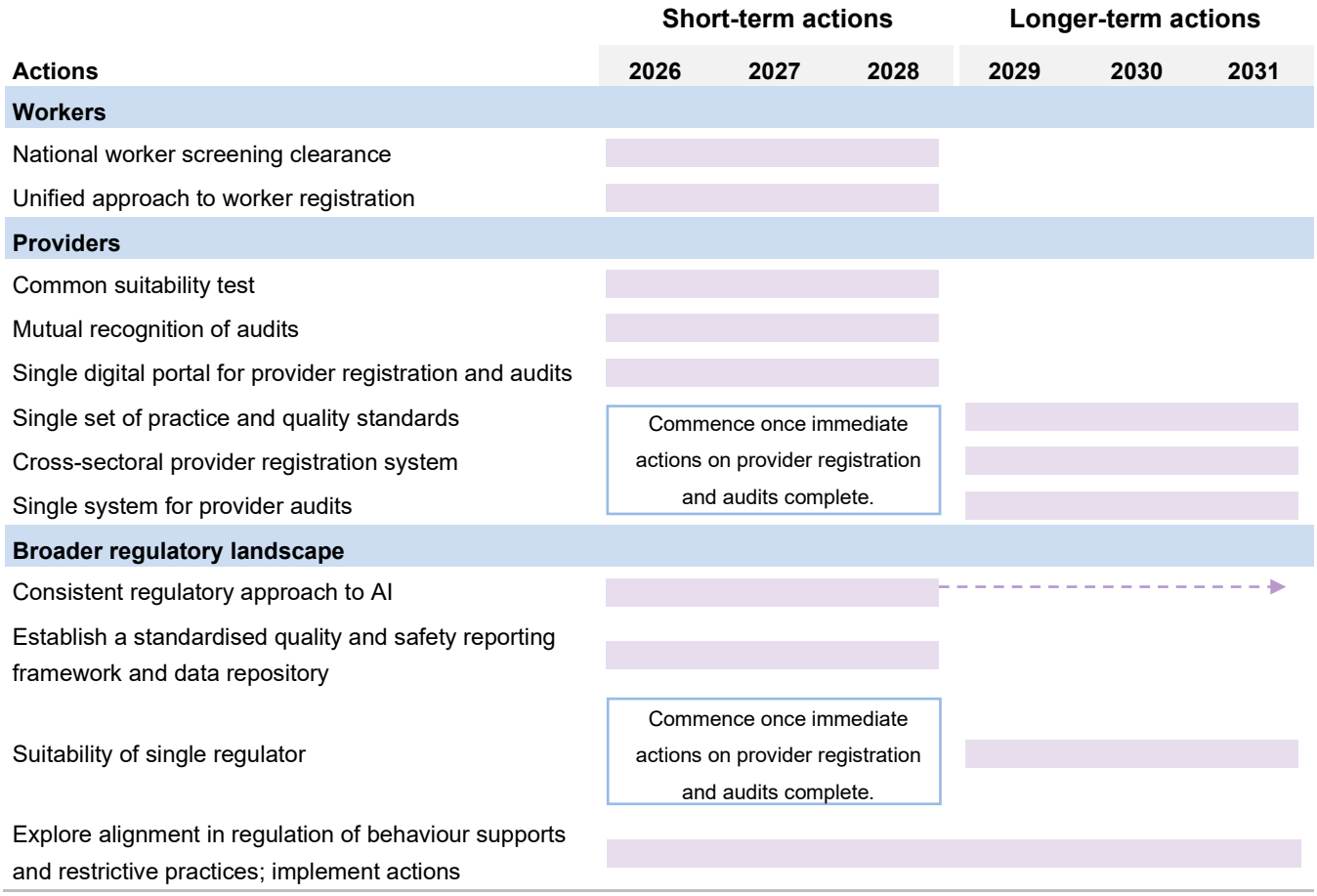
Achieving such a system will be a long-haul journey involving multiple interrelated pieces of work across different care sectors, aspects of regulation and parts of government. To begin, the Australian Government should implement a series of actions focused on aligning regulation in the aged care, NDIS and veterans' care sectors (figure 1.3). Our initial focus on these sectors reflects the significant similarities between them (box 1.2). While, as noted above, differences in services and the needs of care users can justify different approaches to regulation, we consider that the similarities across these sectors justify a more unified approach to regulation than currently exists.

Figure 1.2 – Principles of leading-practice regulation

Regulatory design	Regulatory governance	Regulator conduct
• Objectives of regulation are clearly defined and consistent across different regulations • Consultation during regulation making is sufficient • Regulation is not overly complex or excessively prescriptive • Regulation is reviewed regularly	• Roles, responsibilities and requirements of different regulatory agencies are clear and duplication is avoided • Decision makers are accountable • Regulators are free of undue political interference • Regulators are adequately resourced and have the necessary capabilities	• Regulators' processes are clear, predictable, open and transparent • Regulators use their resources efficiently • Administrative costs are no higher than necessary

Source: PC (2020b).

Figure 1.3 – An implementation plan towards greater regulatory alignment



Although our recommendation focuses on the aged care, NDIS and veterans' care sectors, many of the solutions we identify could be extended to other parts of the care economy over time – we highlight these below where relevant.

Our proposed actions span a six-year implementation horizon (figure 1.3). They do not cover all aspects of regulation that could be better aligned – once our proposed actions have been completed, governments will need to reconvene to determine next steps.

Box 1.2 – The aged care, NDIS and veterans' care sectors share many similarities

Although the aged care, NDIS and veterans' care sectors differ in some ways – for example, a significant portion of NDIS participants are children, whereas the aged care and veterans' care sectors primarily serve older people – substantial similarities between them justify a more consistent approach to quality and safety regulation. These similarities include that:

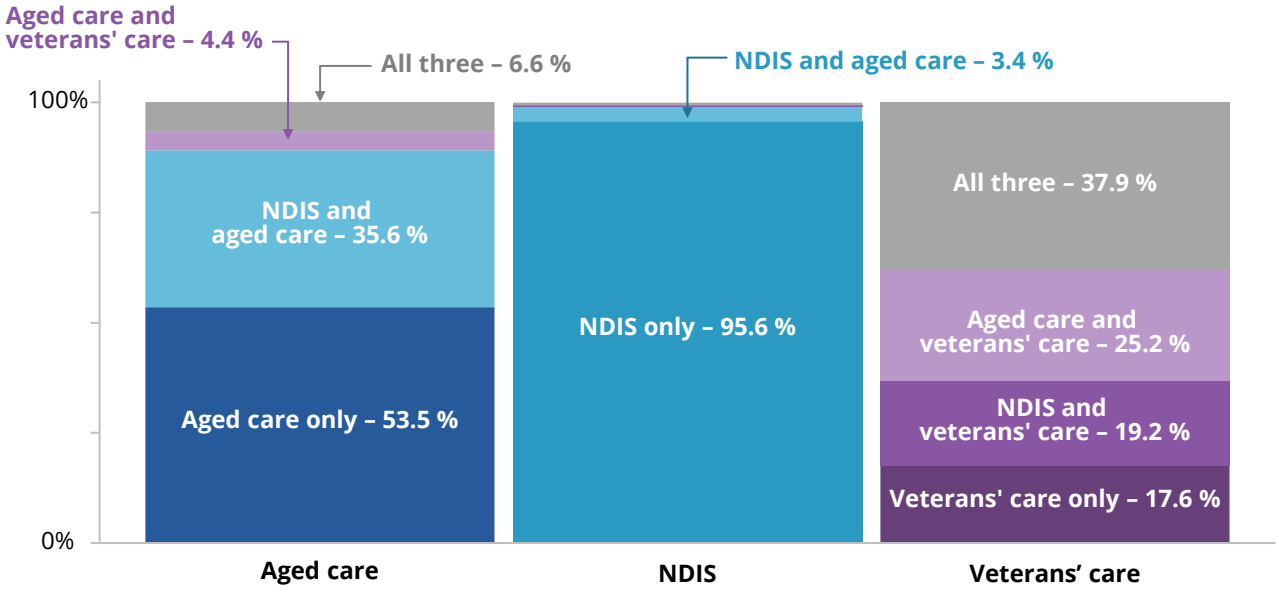
- **service provision and regulation is rooted in the human rights of care users.** For example, one of the objectives of the *National Disability Insurance Scheme Act 2013* (Cth) is to give effect to Australia's obligations under the United Nations *Convention on the Rights of Persons with Disabilities* (s. 3(1)(a)). The new *Aged Care Act 2024* (Cth), starting from 1 November 2025, will also embed a rights-based approach, and include a Statement of Rights that emphasises independence, choice and control (DoHAC 2025b).
- **the types of services provided are similar.** Analysis of the classes of registration and support across aged care and NDIS services show a high level of commonality, with services largely relating to assistance with daily living, personal care, social supports, allied health and therapy services and/or clinical care. Similarly, home care across the aged care and veterans' care sectors offers a similar suite of services that aim to enable people to remain independent in their homes.
- **many providers operate across sectors** (figure 1.4)**.** For example, more than 42% of the approximately 2,132 aged care providers are also registered NDIS providers. These are generally the larger providers of aged care services, meaning they constitute an even greater proportion of services delivered. Eighty-two per cent of veterans' care providers also offer services in aged care and/or the NDIS.
- **the skills required to deliver care are often similar.** For example, a Certificate III in Individual Support allows workers to work across both the aged care and disability sectors in roles such as residential care worker and personal care assistant. While students can specialise in ageing, disability or both, the nine core units of the course and 21 of the 27 possible electives are sector-neutral. Students must select six electives, including at least one of the two sets of three that pertain to specialisation in ageing or disability (Australian Government 2022).
- **some groups of care users share similar characteristics or support needs.** For example, 97% of the Department of Veterans' Affairs' Community Nursing Program and 94% of Veterans' Home Care clients are older than 65, making them similar in age to those accessing aged care services. There are also about 2,400 NDIS recipients currently living in residential aged care (NDIA 2025b).

The next sections set out our proposed actions, split into two main categories: short-term actions to be commenced immediately, which primarily concern streamlining regulatory processes within three years; and longer-term actions that involve more fundamental reform such as aligning systems and standards, to be completed within a further three years. Actions encompass both worker and provider regulatory

requirements, along with those that support user information and choice. While specific actions may be directed toward workers, providers, or the overarching regulatory landscape, combined, they aim to deliver an efficient and aligned regulatory system across care sectors that boosts productivity and ultimately benefits end-users through better quality and more accessible care.

Figure 1.4 – Many aged care, NDIS and veterans' care providers operate across sectors[a]

Proportion of providers in each sector that operate across different sectors



a. Data for NDIS providers is for registered providers only. The large proportion of providers operating only in the NDIS reflects the relatively large number of registered providers in the scheme (approximately 22,000 compared to approximately 2100 in aged care and 370 in veterans' care).

Source: PC estimates using NDIS (2025a), DoHAC (unpublished data) and DVA (unpublished data).

Actions to start immediately and complete within three years

Develop a national worker screening clearance

Governments should establish a single national worker screening clearance that replaces the various existing clearances, such as aged care police checks, NDIS worker screening checks and working with children/vulnerable people checks. This idea is not new – a national worker screening check was listed as a possible output on the reform agenda associated with the new National Competition Policy, which was agreed by governments in November 2024 (Treasury 2024).

A national worker screening clearance would enable workers to apply for a clearance to work across all care sectors and jurisdictions through a single process, with checking automated to the greatest extent possible and supported by effective information sharing between regulators. Real-time continuous checking should be undertaken between renewal dates to ensure prompt action if a worker engages in inappropriate behaviour. This could build on work by the Australian Criminal Intelligence Commission to scope, design and pilot a national continuous checking capability for working with children checks and NDIS worker screening checks (ACIC 2024).

A single national clearance would remove the need for workers to undergo multiple screening processes, reducing administrative burden and application costs. It would also lead to more efficient checking processes and shorten wait times for clearances (both from more efficient checks and from avoiding the need to wait for

multiple checks). Most importantly, it would enable swifter and more effective regulatory responses to workers who engage in inappropriate behaviour, since it would bring together information from disparate databases across sectors and jurisdictions.

Adopt a unified approach to worker registration across aged care, NDIS and veterans' care

Worker registration in the care sector is a topical issue. Most workers in the aged care, NDIS and veterans' care sectors are not required to be registered,[3] but concerns about quality, safety and workforce attrition have led some recent reviews to recommend mandatory registration (Commonwealth of Australia 2023c, 2023d; Wade et al. 2024). For example, the *NDIS provider and worker registration taskforce advice* (Wade et al. 2024, p. 92) said that a registration scheme for NDIS workers, alongside worker screening, would:

> … increase the quality of care and supports, encourage innovation and best practice, upgrade the skills and qualifications of the workforce, and assist in attracting and retaining disability support workers by offering an attractive career path. Further worker registration provides visibility of the NDIS workforce.

The Australian Government has not formally responded to all of the recent reviews looking at worker registration, but is developing a national aged care worker registration scheme (DoHAC 2025a).

This inquiry has not examined whether the Australian Government should require registration of care workers in the aged care, NDIS or veterans' care sectors, or the standards that should be embedded into any worker registration scheme. We note that workforce regulation should strike a balance between ensuring appropriate safeguards for quality and safety and avoiding creating unnecessary barriers to workers entering or moving within the workforce, as set out in the PC's inquiry into *Building a skilled and adaptable workforce* (PC 2025a). However, if the Australian Government does decide to require care worker registration in multiple of these sectors, it should establish a single national, cross-sectoral system rather than separate schemes for each sector. The absence of existing schemes in the three sectors provides an opportunity to ensure a unified approach from the outset, which will avoid the need to bring disparate schemes into alignment in the future.

The single registration system, if the government decides to require registration, should allow workers to register once in order to work across the aged care, NDIS and veterans' care sectors, as long as they meet the conditions of their registration. Registration conditions should not be sector-specific unless absolutely necessary. Different classes of registration could be used to accommodate different skills, qualifications or experience requirements, but registration classes should not be tied to any particular sector by default. The system should also recognise existing registration schemes, such as the National Registration and Accreditation System for health practitioners.

In addition, a single user portal should support the registration system, allowing workers to easily view, renew or update their registration, including when applying for new registration classes. This would reduce costs to workers and governments in administering the system.

The overall benefits of a single system will depend on how many workers are required to be registered (noting registration itself is a cost for workers) and how many work across sectors. The more workers covered and the more they work across sectors, the larger the benefits. Without better information on these parameters, however, it is difficult to estimate the net benefits of this measure.

[3] Exceptions include registered nurses, enrolled nurses and nurse practitioners who must formally register with the Australian Health Practitioner Regulation Agency (AHPRA).

Actions related to provider registration, accreditation and audits

The Australian Government should take three actions in the short term to reduce duplication in provider registration, accreditation and audits. These actions relate only to the aged care, NDIS and veterans' care sectors, rather than the broader suite of health and social services – however, they will reduce the overall accreditation and audit burden for cross-sector providers. And, as noted below, several of these solutions could be extended to other services or sectors over time, delivering further benefits.

These actions also only deal with streamlining processes rather than overcoming more fundamental differences in provider registration and audit arrangements across the three sectors. We propose further actions to address these differences later in this chapter.

Develop a common suitability test across sectors

Providers in aged care, NDIS, veterans' care and ECEC must all demonstrate their suitability to operate a care business, for example, by demonstrating sound governance and operational management. These assessments are often very similar and can require the same types of documentation.

The Australian Government should consolidate these requirements into a single, common suitability test that providers complete once for all four sectors. Providers should be required to re-demonstrate their suitability periodically, or when their circumstances change. Over time, these arrangements could be extended to other services or sectors.

Establish mutual recognition of audits across aged care and NDIS standards

In addition to having to demonstrate their suitability, aged care, registered NDIS and some veterans' care providers are assessed against the NDIS practice standards and/or aged care quality standards, which are substantially similar. The Australian Government should establish mutual recognition arrangements, so that compliance with the aged care sector's standards can be accepted as evidence of compliance with equivalent or less onerous standards in the NDIS, and vice versa. This approach would reduce the time and costs of audits for providers and government, without compromising the standards that providers have to meet.

A 'modified NDIS residential aged care audit' currently allows residential aged care providers supporting NDIS participants to be assessed against the NDIS practice standards through a desktop review of their most recent aged care audit (NDIS Quality and Safeguards Commission 2022, p. 1). But no broader mutual recognition arrangements exist for other types of aged care or NDIS providers or for veterans' care providers required to adhere to the aged care standards.

Mutual recognition would require mapping and verifying the equivalence of standards. While the NDIS practice standards have been compared to the current aged care quality standards (NDIS Quality and Safeguards Commission 2025), the PC is not aware of any mapping to the strengthened quality standards coming into effect in November 2025.

Create a single digital portal for provider registration and audits

To reduce the number of contact points with regulators and centralise information about a provider's registration and audits, a single provider portal should be developed for the aged care, NDIS and veterans' care sectors. This portal would:

- store and present information about a provider's registrations and audits in the three sectors (as relevant), allowing providers to view and manage these details in one place
- allow providers to upload documentation and other evidence related to registration and audits, which would be accessible to all relevant regulators as necessary, reducing the need for providers to submit the same or similar information multiple times to different regulators

- contain a provider's audit compliance history, which could be used to support mutual recognition of audits across the three sectors.

Over time, these functions could be extended to other care sectors, further reducing duplication and complexity for providers operating across sectors.

A single portal would be able to reduce the burden of compliance for providers even though the rules and arrangements across sectors currently differ, since there is significant overlap in many of the underlying standards and the types of evidence providers are required to produce. That said, the portal would also serve as a stepping stone towards a single provider registration and audit system across the aged care, NDIS and disability sectors, as proposed later in this chapter.

Establish a standardised quality and safety reporting framework and data repository to reduce reporting burden and enable more consistent public reporting

Governments should establish a standardised quality and safety reporting framework for providers to reduce duplication in reporting, support better performance monitoring and improve transparency. More consistent quality and safety data can help regulators identify providers with performance concerns and enable users to more easily compare providers and make informed decisions about their care.

Care providers are often required to report similar information to different regulators under separate contracts, service agreements and legislated quality and safety regimes. A standardised framework would streamline these requirements by identifying a common set of indicators, allowing providers to report once and have that data used for multiple purposes. For the framework to be effective, contracts, service agreements and other reporting requirements must reflect the common set of indicators.

The framework should be underpinned by a shared data repository that regulators can access as required. This would reduce the need for providers to submit the same information to different bodies.

A common set of indicators would also make it easier for governments to compare performance across sectors and measure productivity in the care economy, and support more meaningful public reporting of services across the care economy. Public reporting would also allow care users to compare services using clearer and more accessible information, improving decision-making and accountability while helping providers understand how they perform relative to others. Benchmarking, in turn, can support service improvement and innovation.

While no single framework will eliminate all duplication in reporting or provide a comprehensive overview of all care sectors, a standardised framework should aim to achieve this as much as possible. Governments should follow the principle of 'report once, use often', and aim to reduce burden without compromising the quality or usefulness of data.

Governments will need to determine what sectors and indicators the framework should cover. To begin, governments should identify the areas of greatest overlap in current reporting requirements for providers operating across the aged care, NDIS and veterans' care services, which are the focus of our proposed actions. These overlaps should inform the indicators in the framework in the first instance.

Over time, governments should consider extending the framework to more care services.

To better scope our recommendation regarding this proposed action, we are seeking further information and ideas on a standardised reporting framework and data repository. We are also seeking examples of standardised reporting frameworks that have effectively reduced reporting burden for providers, and suggestions on what information could be publicly reported to support service improvement.

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?

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

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

Adopt a consistent regulatory approach to artificial intelligence (AI) to facilitate its adoption

AI is a relatively new technology that is already showing considerable promise in improving care outcomes and productivity in the care economy (box 1.3). In this context, government agencies are beginning to grapple with how to ensure its safe and responsible use (DoHAC 2024). There is an opportunity to ensure that governments adopt a cohesive regulatory approach for this purpose from the outset, rather than allowing sector-specific approaches to develop which create complexity and inconsistency and limit the ease with which care providers can take advantage of AI in the future. We consider that a consistent approach across aged care, NDIS and veterans' care is appropriate given that regulation would be addressing similar potential risks in similar settings.

Box 1.3 – How is artificial intelligence (AI) improving outcomes and productivity in the care economy?

AI is a promising tool for improving productivity across the care economy, with potential benefits including greater independence and quality of life of care users and reduced costs and improved efficiency for providers. It can also help relieve workforce pressures and allow providers to direct more resources to caring.

In Australia, examples of applications (or trials) of AI in the care economy include:

- screening and diagnostics, including skin imaging, to support clinicians in the early detection of melanoma (Melanoma and Skin Cancer Trials Limited nd; PC 2024c, p. 76)
- scribes to support medical record-taking (RACGP 2025a)
- conversation agents and chatbots that can connect care users to information and provide discreet and timely advice (PC 2024c, p. 75)
- wearable devices and remote patient monitoring technologies that enable clinicians to detect escalations and complications earlier, and intervene to prevent adverse outcomes (PC 2024c, pp. 54–58)
- AI-driven prosthetics and responsive wheelchairs that offer people with disability increased control, natural movement and greater autonomy (Centre Disability Support 2025).

Box 1.3 – How is artificial intelligence (AI) improving outcomes and productivity in the care economy?

AI also holds the potential to enhance governments' effectiveness in stewarding or regulating the care sector. For example, AI could help regulators identify higher-risk providers, perform administrative paperwork more efficiently, and compare results to historical patterns (Gracie et al. 2023). It could also help with reducing the complexity and burden of regulation, for example by generating information from existing sources in the format required by regulators, rather than requiring providers to submit that information in bespoke formats. As with any technology, however, automation needs to be deployed with human oversight to ensure it works as intended.

A consistent approach does not necessarily mean a bespoke regulatory framework. For example, regulators could instead adopt consistent regulatory practices under their respective legislation. In keeping with the PC's previous publications and its inquiry into *Harnessing data and digital technology*, regulators should use an outcomes-focused, stepped approach to consider how existing regulation can be applied and extended to AI, prior to developing new AI-specific regulation (PC 2024d, pp. 5–8, 2025c). Part of this consideration is balancing sufficient regulatory protection with enabling the adoption of new technologies, which can lift quality of care. If new regulation is required – noting that it should be a last resort (PC 2025b) – it should be risk-based and technology neutral to support adaptation to rapid technological change. Regulators should also be cognisant of international regulation and the risk of AI suppliers bypassing Australia if Australian standards depart from global norms (PC 2024d, pp. 9–11).

Actions to complete within a further three years

In addition to the short-term actions above, the Australian, state and territory governments should seek more fundamental alignment in regulatory standards within a further three years. The Australian Government should create a single set of practice and quality standards across the aged care and NDIS sectors, establish a single provider registration and audit system for these and the veterans' care sectors, and explore the suitability of a single regulator across all three sectors. In addition, the Australian Government, in collaboration with state and territory governments, should explore the potential for greater alignment in the regulation of behaviour support plans and use of restrictive practices focusing on the aged care and NDIS sectors, and implement agreed actions.

The goal of these reforms is to reduce unnecessary complexity in regulation across sectors while upholding or improving outcomes, making the system more effective and easier for care users and providers to navigate, and reducing regulatory burden on providers, which will enable them to direct more attention towards providing quality care.

Create a single set of practice and quality standards

The aged care quality standards (which become strengthened quality standards from 1 November 2025) and the NDIS practice standards should be combined into a single set of practice and quality standards. These unified standards will likely need to be modular to accommodate different service types – for example, there could be core modules that apply to most or all providers, and supplementary modules that apply depending on the type of services delivered. Regardless, the unified standards should establish common standards for similar types of services across sectors.

Previous mapping of the NDIS practice standards to the aged care quality standards has already shown that these standards have many commonalities (NDIS Quality and Safeguards Commission 2022, p. 2). This mapping would need to be updated for the strengthened quality standards, but preliminary work suggests even greater similarities, enhancing the case for a common set of standards. A single set of standards is also a necessary (but not sufficient) foundation for a single provider registration and audit system.

Develop a cross-sectoral registration system for providers

Further to developing a common suitability test and creating a single digital portal for provider registration, the Australian Government should develop a cross-sectoral provider registration system for the aged care, NDIS and veterans' care sectors. This system would only apply to providers that are required to be registered or who choose to do so voluntarily (as some NDIS providers do).

A single registration system would mean that providers across sectors undergo the same process to be registered, register into the same set of service categories, have the same audit requirements and are able to work across the different sectors within their registration category without having to register again. This would reduce the time and costs associated with multiple registration processes and could encourage providers to offer their services across multiple sectors, increasing the availability of services for care users.

In recommending a cross-sectoral registration system, we are aware of the ongoing debate regarding the universal registration of providers in the NDIS, but have not examined this issue. A related question, however, is whether there should be *consistency* in the types of providers across sectors that are required to be registered – that is, whether providers that offer similar types of services across sectors should be subject to the same registration requirements.

A consistent approach to who is required to be registered appears desirable in principle. Providers and care users would spend less time understanding the different requirements for seemingly similar services. However, differences in the design of the aged care system and the NDIS could make achieving consistency challenging. For example, differences in how 'providers' are defined could make it difficult to design and implement a consistent set of rules that is relevant and appropriate across all settings.[4] Over time, it would be desirable to explore how these differences could be overcome and how consistency could be achieved in the types of providers required to be registered.

Establish a single system for provider audits

Audits are a key part of quality and safety oversight and are often linked to registration or accreditation processes. The Australian Government should establish a single audit system across the aged care, NDIS and veterans' care sectors that contains a consistent set of rules outlining the types and frequency of audits providers will be subject to, based on the types of services they deliver and/or registration class (if applicable), and the standards that providers will be audited against.

A single audit system should also set out clear and consistent arrangements around *who* conducts audits. At present, the Aged Care Quality and Safety Commission conducts audits of aged care services, whereas NDIS providers engage their own private auditors. The Department of Veterans' Affairs conducts veterans'

[4] In the NDIS, a provider is any person, business or organisation that delivers NDIS-funded supports to NDIS participants (NDIA 2024). This can include businesses that cater to the wider population, rather than NDIS participants only. In contrast, providers in aged care are those that have been accredited, approved or (as of 1 November) registered to deliver aged care services.

care audits. A clear and consistent set of rules would ensure audit arrangements are fair and consistent and that providers can understand and plan for what is required.

Explore the suitability of a single quality and safety regulator

A single quality and safety regulator would combine the Aged Care Quality and Safety Commission, the NDIS Quality and Safeguards Commission and the regulatory functions of the Department of Veterans' Affairs into a single statutory agency.

A single regulator would be a natural extension of a single set of standards, and common registration and audit requirements. It would streamline oversight of these sectors, replacing fragmented responsibilities with a more coordinated, consistent and efficient system. It would reduce confusion for providers and care users about roles and responsibilities (for example, who to make complaints to) and eliminate duplication in functions such as compliance monitoring and enforcement.

A single regulator would also be better positioned to gather the regulatory intelligence required to ensure the quality and safety of services, including by monitoring risks across sectors and identifying emerging issues. It would be well placed to report on quality and safety across the care sector and to support benchmarking and innovation. This would lift the overall standard of care in these sectors and improve trust and confidence in the system.

The Australian Government should assess the case for a single quality and safety regulator. To begin exploring this issue, the PC is seeking further information about costs, benefits and risks, and any potential consequences (positive or negative) for the quality of care and safety for care users.

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?

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?

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

Explore greater alignment in the regulation of behaviour support plans and restrictive practices

The Australian Government, in collaboration with state and territory governments, should explore how to better align the regulation of behaviour support plans and restrictive practices in aged care and NDIS services. While both systems aim to protect the rights and safety of care users, they use fundamentally different approaches and processes. Inconsistent state and territory regulations further complicate the situation. Different practices and processes may be distressing and confusing for care users who reside in aged care and receive NDIS services, or who transition from one care setting to another. This includes knowing how to exercise their rights, for example knowing to whom and what processes they need to follow to make a complaint or have a decision reviewed. Different approaches can similarly create confusion on

roles, obligations and reporting requirements among workers and providers operating across multiple sectors, risking inappropriate use of restrictive practices within a care setting (Ageing Australia, sub. 20, p. 2; Council for Intellectual Disability 2025, p. 9; Dementia Australia 2025, pp. 2–3; The Intellectual Disability Rights Service Inc 2025, p. 4).

The benefits from aligning these regulatory approaches could be large for the individuals affected, but this area of regulation is also highly complex, with implications that go beyond aged care and NDIS. Before any reforms are introduced, governments need to do more work to understand what changes are possible and appropriate. This work should be conducted over the six-year horizon of our proposed actions, with clear decision points on the extent of alignment and milestones to guide implementation over time.

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?

Effective implementation requires persistence

As outlined in box 1.1, the Australian Government has made several attempts in recent years to align regulation across the care economy. But these efforts have lost momentum in the face of:

- competing priorities – a swathe of recent reviews and royal commissions across different care sectors has created pressure on governments to act. While governments have rightly focused on addressing the serious issues raised in these inquiries, most resulting reforms have been sector-specific, making it harder to take a more holistic approach across the care economy
- fragmented responsibilities – responsibilities for regulating the care economy are spread across different departments and agencies. This fragmentation has made coordination difficult, particularly given the pace at which reforms have been introduced in response to reviews and royal commissions
- resistance to further change – significant change within some care sectors in recent years has led to a reluctance for further disruption.

Despite these challenges, recent developments may provide an opportunity to pursue greater regulatory alignment. All relevant reviews and royal commissions over the past few years have now reported, giving the Australian Government an opportunity to take stock and identify opportunities for more consistent regulation across sectors. In addition, in May 2025, the Australian Government Minister for Health and Ageing was appointed Minister for Disability and the NDIS, and disability policy at the Commonwealth level was moved into the newly created Department of Health, Disability and Ageing (Commonwealth of Australia 2025; PMC 2025). These changes reduce fragmentation and create clearer responsibility for aligning aged care and NDIS regulation.

These developments, as well as previous stakeholder consultations that highlight the key issues and proposed possible solutions (DoH 2022), have paved the way for immediate action on greater regulatory

alignment. The focus – and challenge – must now be on sustaining effort over an extended timeframe. This report provides practical steps to achieve this vision for regulatory alignment across the care economy.

To successfully lead the reform agenda, the Australian Government must clearly set out its vision for alignment, communicate the benefits and work with stakeholders to achieve results. In addition, it should give the lead agency, whichever is chosen, sufficient authority to bring government agencies together to progress the alignment agenda. The Australian Government must therefore clearly communicate the alignment mandate across government agencies and create the conditions for it to succeed.

Finally, as noted above, regulatory reform will never be a ‘set and forget’ task. It must continue to evolve alongside the care system and broader economy and keep pace with the opportunities available from new technologies, including AI. At the end of the six-year timeframe – or once our proposed actions have been completed – governments will need to assess and determine the next steps to further reduce regulatory burden and improve outcomes in the care economy.

2. Embed collaborative commissioning to increase the integration of care services

Summary

- **Australia's care system is fragmented. Multiple organisations working under different levels of government share responsibility for delivering services. This leads to duplication and gaps, particularly at the interfaces between different parts of the care sector. It worsens outcomes for care users.**
  - Collaborative place-based approaches that promote local autonomy and accountable service delivery can focus services on local needs, reduce fragmentation, and foster new innovative models of care, improving productivity and delivering better care.
- **Collaborative commissioning – where organisations work in partnership to plan, procure and evaluate services to address local needs – can improve the integration and experience of care. But governments have not realised their ambition to embed collaborative commissioning.**
  - Governments should focus first on greater collaboration between Local Hospital Networks (LHNs), Primary Health Networks (PHNs), and Aboriginal Community Controlled Health Organisations (ACCHOs). These bodies are strongly interdependent, but their responsibilities are blurred and incentives can be misaligned.
  - The benefits of collaborative commissioning are diverse and difficult to estimate. But even a modest (10%) reduction in potentially preventable hospitalisations could deliver savings of $600 million per year.
- **To embed more collaboration, reforms to joint governance arrangements and funding are needed. This is expected to improve both the efficiency of government spending and care outcomes, increasing the productivity of health care.**
  - LHNs and PHNs, in partnership with ACCHOs and other organisations, should plan together, undertaking joint needs assessments to determine areas of overlap and mutual interest. LHNs and PHNs should develop agreed programs of work, undertake joint monitoring and report against agreed shared outcomes.
  - More flexible funding would enable LHNs and PHNs to work together to address local needs. Dedicated funding for collaborative programs to address local gaps in care, including initiatives that improve health outcomes, reduce potentially preventable hospitalisations and reduce future costs, may be required. A funding adjustment based on whether agreed shared outcomes are achieved would embed successful programs.
  - Australian and state and territory governments need to agree on these reforms, and negotiations on the next five-year addendum of the *National Health Reform Agreement* (NHRA) provide that opportunity.

Draft recommendation

Draft recommendation 2.1
Governments should embed collaborative commissioning, with an initial focus on reducing fragmentation in health care to foster innovation, improve care outcomes and generate savings

In the next addendum to the *National Health Reform Agreement*, governments should agree to governance and funding arrangements that support better collaboration between Local Hospital Networks (LHNs), Primary Health Networks (PHNs) and Aboriginal Community Controlled Health Organisations (ACCHOs).

New joint governance arrangements to support collaboration are needed.

- LHNs and PHNs should be required to plan together to identify areas for collaboration, including joint needs assessments, agreed plans of work and joint monitoring and reporting of outcomes.
- LHNs and PHNs must work in partnership with ACCHOs and other organisations to inform planning and shared decision making. Partnering with ACCHOs should be consistent with the principles set out in the National Agreement on Closing the Gap to ensure relevant needs are appropriately and respectfully assessed and key decisions are shared.
- There needs to be stronger requirements for formal joint collaborative commissioning committees and the development of data-sharing arrangements to underpin joint needs assessments and evaluation of outcomes.

Changes to funding arrangements are also needed to embed collaborative commissioning.

- Barriers to pooling funding or other forms of joint commissioning should be removed. The Australian Government should make funding for PHNs more flexible. State and territory governments need to ensure that service agreements provide flexibility in the services and programs that LHNs can fund.
- LHNs, PHNs and ACCHOs should be sufficiently resourced to undertake comprehensive joint governance.
- The Australian Government should provide LHNs and PHNs with sufficient dedicated funding to embed collaborative commissioning programs once they submit a joint plan. The joint plan should clearly link agreed shared outcomes to enhanced productivity in the form of quality improvements or more services that lower potential future costs. Initially, the focus should be on reducing potentially preventable hospitalisations. Future funding should be adjusted based on whether agreed shared outcomes have been achieved at the local level.

Collaborative commissioning can improve outcomes

Poorly integrated care produces worse outcomes for care users

Australia's care system is fragmented. Multiple organisations working under different levels of government provide services across various types of care. Yet these services can often relate to the same person for the same need. For example, a person who first requires primary health services from their doctor might then need services through hospitalisation and then require further primary health services when they get home from hospital. The current structure of care services is siloed, and complex governance and disconnected funding arrangements produce inefficiencies, cost shifting and discontinuity of care (Peiris et al. 2024). The current system relies on activity-based funding and fee-for-service funding models which 'reward throughput,

rather than better health outcomes or prevention' (The George Institute for Global Health and The Leeder Centre for Health Policy, Economics and Data, qr. 72, p. 3).

Unfortunately, there are not sufficient embedded processes in place to ensure systemic collaboration across these organisations and tiers of care services even though care users would benefit greatly if they did.

Fragmentation prevents people from receiving comprehensive and coordinated support. Gaps in care typically occur at the interfaces between different parts of the sector, such as between the acute, primary, disability and aged care sectors. Examples include the following.

- Lack of access to primary care can increase hospitalisations. People with chronic or complex conditions may not receive comprehensive general practitioner (GP)-led care linked to allied health services and outreach programs, resulting in poorer health outcomes and avoidable use of hospital services. In 2023-24, an estimated 2.8 million emergency department presentations could have been tended to by a GP (SCRGSP 2025c, p. 28).
- Discharge from hospitals can be impeded by lack of access to housing, aged or disability care services, particularly in rural and regional areas. People who are not discharged from hospital in a timely manner can have worse outcomes, while the availability of acute care beds for others is reduced.
- Transition between the National Disability Insurance Scheme (NDIS) and aged care can change funding and service access. Funding per person varies between the schemes, meaning that older Australians with disability are not necessarily accessing the services that best meet their needs (Commonwealth of Australia 2023d, p. 70).

Place-based collaborative commissioning can improve outcomes and save money

Collaborative commissioning describes organisations working in partnership to identify needs, design solutions, procure services and evaluate outcomes (figure 2.1). Collaborative commissioning holds significant potential for making Australia's care system more integrated and productive. It is a more holistic approach than simply procurement: it is a continuous cycle that involves planning, design and evaluation of outcomes to inform future planning and refinement of service design.

The Productivity Commission is proposing a formalised process for the different tiers of government and different services organisations to 'collaborate' on those services and care needs that overlap (or where there are gaps).

Collaborative commissioning can support more integrated care by helping to align the planning and provision of services between different organisations and types of care, contributing to a more seamless experience for care users, particularly people with chronic or complex conditions. These benefits were highlighted by participants in the inquiry.[5] For example:

> Integrated service delivery structures are needed to better support accessible, more patient-centred health services offered closer to home for diverse populations … (Royal Australian College of Physicians, qr. 64, p. 4)

> The benefits of collaborative commissioning include reduced duplication of service delivery, improved coordination between acute and primary care, enhanced integration and multidisciplinary models … (Murrumbidgee Primary Health Network, qr. 130, p. 3)

[5] AHHA, sub. 26, pp. 10–11; Uniting NSW/ACT, qr. 53, pp. 2–3; Health Consumers' Council WA, qr. 48, pp. 2–3; the Health Alliance, a joint initiative of Metro North Health and Brisbane North PHN, qr. 70, pp. 2–3.

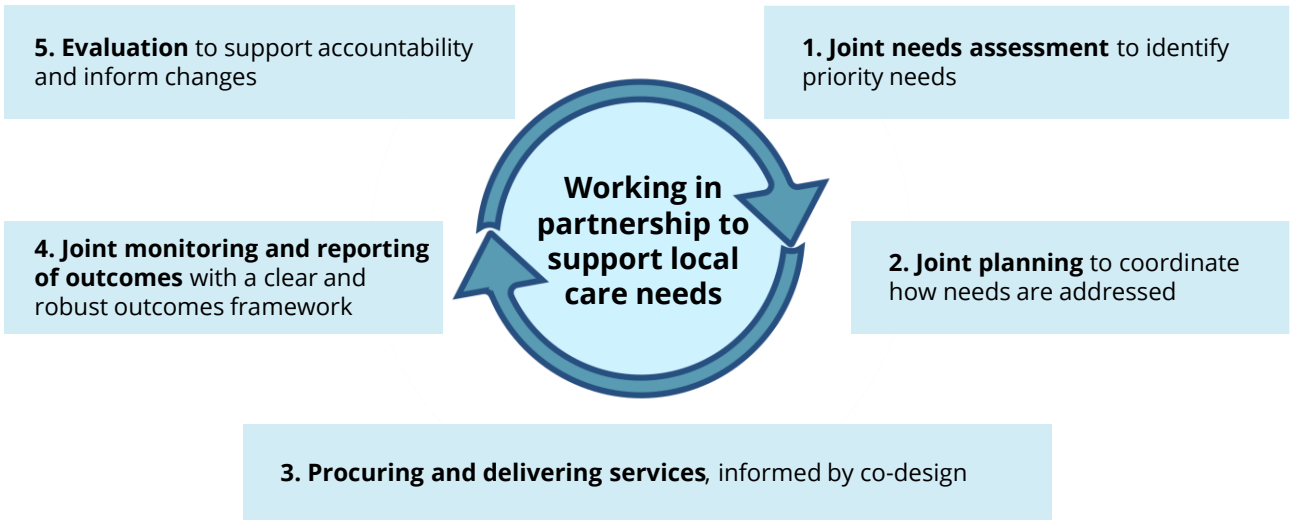
> Well-executed collaborative commissioning could help solve some of Australia's toughest health-system problems, including fragmentation, inequity, a focus on volume instead of value, and weak consumer voice in service planning and design. (Grattan Institute, qr. 56, pp. 1–2)

Collaborative commissioning can also improve productivity through more efficient use of government funding. It can reduce inefficient duplication and provide more effective, joined-up care to clients (Centre for Policy Development, qr. 96). Collaborative commissioning can also reduce the need for more costly services, such as hospitalisations. The Health Consumers' Council WA (qr. 48, pp. 2–3) highlighted this issue:

> We see this particularly in patients who would be well served by seeing GP but have instead presented to an emergency department either because they were unable to get an appointment with a GP, couldn't afford the upfront and/or out of pocket costs, or because the GP is closed.

Even small reductions in potentially preventable hospitalisations (PPHs) – say 10% – could provide cost savings of $600 million a year, slowing the escalating growth in health care spending.

Figure 2.1 – Collaborative commissioning involves organisations working together in a continuous cycle



Collaborative commissioning also makes it easier to adopt a place-based approach (OECD 2025b) to care services, with organisations in a local community or region working together to coordinate and tailor services to local needs, reducing the gaps in available services and making it easier for people to access them.

Aboriginal Community Controlled Health Organisations (ACCHOs) embody a successful integrated place-based approach that embeds a flexible and responsive approach to care, and seeks to influence the social determinants of health:

> ACCHOs are an excellent and longstanding example of 'integrated commissioning'. They deliver primary health care services to communities as well as preventive and population health activities, justice health initiatives, aged care and disability services, mental health, allied health, childcare and many other services. … programs commissioned by community controlled peak bodies such as NACCHO understand the needs and challenges of the sector, and support flexible local level decision making to optimise service delivery and outcomes for Aboriginal and Torres Strait Islander people and communities. (NACCHO, sub. 32, p. 10)

Place-based collaborative commissioning approaches have been adopted or are in train in the United Kingdom, Canada and New Zealand (Boer et al. 2025; NZ SIA 2025; The King's Fund 2023). Similarly, the recent PLACE initiative, co-funded by the Australian Government and philanthropic organisations, is intended to support community-based initiatives to tackle entrenched disadvantage (PLACE 2024).

Case studies of collaborative commissioning initiatives demonstrate the potential gains from better integrated care at the local level (boxes 2.1 and 2.6). These benefits include improved patient outcomes, including access to more culturally appropriate care for Aboriginal and Torres Strait Islander people, and reduced avoidable hospital admissions. Examples of effective collaborative commissioning initiatives include:

- The Health Alliance, a partnership between Metro North Health and the Brisbane North Primary Health Network (PHN), identified a cohort of complex patients and placed a Complex Care Coordinator within GP practices to support these patients and avoid emergency department presentations. Evaluation of the program has shown reduced emergency department presentations and savings (Huxtable 2023, p. 69).
- The Aged Care Emergency Service program, a nurse-led initiative between the Hunter New England Local Health District (LHD), Hunter New England Central Coast PHN and Hunter Primary Care, was developed following the identification of a high number of aged care residents that were frequently presenting to hospital emergency departments. The program pooled financial and in-kind resources from aged care providers, the LHD and PHN, and has better integrated hospitals and aged care facilities through streamlined nurse communication and support. The program has been shown to support quality care and reduce emergency department presentations and hospital admissions (Conway et al. 2015; Hullick et al. 2021).

Finally, collaborative commissioning can facilitate shared learning and diffusion of innovation. Catholic Health Australia (qr. 65, p. 6) noted that 'it creates opportunities to test new models of care, leverage data more effectively, and share best practice'. This could include the innovative use of linked administrative data sets and artificial intelligence (AI) to identify populations who could benefit most from targeted interventions. For example, the US-based Kaiser Permanente has used predictive analytics, including 'patient comorbidity and physiologic parameters, to calculate a risk score that predicts, up to 24 hours before clinical deterioration, whether a patient needs placement in an intensive care unit' (Permanente Medicine 2017, p. 1).

Box 2.1 – Collaborative commissioning for frail and older people in Northern Sydney

The Northern Sydney LHD and PHN co-designed a program aimed at better managing frail and elderly people to improve patient outcomes and reduce emergency department demand.

The LHD and PHN jointly manage the initiative, which is funded under NSW Health's Collaborative Commissioning program. A needs assessment identified elderly people as a priority cohort, finding a 12.5% increase in the number of people aged 75 and older using the emergency department between 2014 and 2019, far outpacing the population growth rate of 4.4%. It also found that the priority cohort could be better managed in the community through embedding existing LHD Hospital in the Home and Rapid Response programs in primary care.

This collaborative approach better aligned incentives between primary care and hospitals, through the PHN effectively engaging GPs to monitor high-risk hospital patients in the community and enabling integration with LHD services. This was supported by financial incentives to GPs, streamlined communication across services and the identification of high-risk patients through shared data.

Box 2.1 – Collaborative commissioning for frail and older people in Northern Sydney

This integrated approach to care resulted in 14,619 referrals to the LHD's Geriatric Rapid Response service between 2022 and 2024, with 80% of patients being managed in the community without an emergency presentation within the week (Inglis et al. 2025). In 2023, the program reduced emergency department visits and unplanned hospital admissions by 51%, saving $10.9 million (AHHA 2024).

The program's success was attributed to the time the LHD and PHN invested in forming their partnership, seed funding that enabled joint planning, an iterative and data-led approach to service implementation, and change management support delivered by the PHN.

Source: Hanfy and Barnard (2023); Peiris et al. (2024, pp. 4–7).

Governments have ambition to embed collaborative commissioning, but barriers remain

Governments have long expressed an ambition to increase collaboration and integration in the care economy. It is a stated objective in the National Health Reform Agreement (NHRA), PHN strategy and the National Mental Health and Suicide Prevention Agreement (which the PC is currently reviewing). The NHRA mid-term review recommended pursuing greater alignment and collaboration between PHNs, Local Hospital Networks (LHNs)[6] and ACCHOs, and that these bodies plan and commission in partnership.

While initiatives such as the NSW Health Collaborative Commissioning program and the Australian Government's Integrated Care and Commissioning initiative show encouraging signs, progress towards a consistent, national approach to collaborative commissioning remains limited. Existing policy initiatives largely consist of piecemeal programs and trials, and success often depends on the happenstance of committed individuals reaching agreement. Systemic barriers can frustrate rather than foster collaborative approaches. Barriers identified by participants have a large degree of interplay and overlap, but include:

- **difficulty moving beyond trials**. Resources allocated to try new approaches are relatively small-scale trials or pilots with limited time frames. Secure and stable long-term support for proven effective programs is inadequate.
- **rigid and short-term funding**. The objectives of regional bodies such as PHNs and ACCHOs to meet their local health needs are misaligned with funding processes, which offer little flexibility to address local needs or certainty to sustain effective programs (the Health Alliance, a joint initiative of Metro North Health and Brisbane North PHN, qr. 70, p. 3; Uniting NSW/ACT, qr. 53, p. 3; VACCHO 2024, pp. 51–53).
- **capability constraints**. Prescriptive requirements and small budgets can limit the capacity of organisations to meet their objectives, and prevent them from attracting, retaining and training staff. These constraints can affect the capacity of organisations to engage in collaborative commissioning.
- **the lack of formal joint governance architecture**. The absence of formal prescriptive collaboration requirements means there is no authorising environment that makes collaborative approaches the default. Instead, collaborative approaches occur despite the system, and success relies on the motivation and goodwill of individuals. When these individuals leave, initiatives can cease.

[6] Terminology varies across jurisdictions – LHNs include Health Service Providers, Hospital and Health Services, Local Health Districts, Local Health Networks and Local Health Service Networks.

- **misaligned incentives**. The siloing of organisations and their funding arrangements inhibits collaboration (Advanced Pharmacy Australia, qr. 60, p. 4; Catholic Health Australia, qr. 65, p. 7). Misaligned areas of geographical responsibility (such as some of the boundary misalignment between LHNs and PHNs) can also prevent collaboration.
- **data and evaluation constraints**. Data sharing arrangements can be difficult and time consuming to establish, frustrating opportunities to collaborate (Fixing the NDIS research team, Centre for Disability Research and Policy, The University of Sydney, qr. 31, p. 5; Catholic Health Australia, qr. 65, pp. 7–8).

First, embed collaborative commissioning between LHNs and PHNs

Embedding collaborative commissioning requires governments to change the way they fund and provide care, and to put the architecture in place to enable collaboration to become business as usual.

While collaborative commissioning can apply across the care economy, focussing on collaboration within the health sector – in particular, between LHNs and PHNs, and how they partner with ACCHOs and other organisations – is an obvious starting point, for a few reasons.

First, activities in one part of the health sector can substantially affect the demands on other parts of the sector. Importantly, access to timely and appropriate primary care services, such as those provided by GPs, can reduce the likelihood of people being hospitalised. Equally, improving outcomes for patients discharged from hospital, and reducing their risk of readmission, can require increased or different primary care support.

Second, the division of responsibilities between parts of the health sector are blurred. Broadly, state and territory governments, through LHNs, manage hospitals, while primary care is largely the responsibility of the Australian Government, which subsidises services by health providers (such as GPs) through the Medicare Benefits Schedule, and provides grants to PHNs to commission services. But LHNs also provide some primary care services, such as preventive and chronic condition management services and community care. In practice, hospital emergency departments provide a substitute for services provided by GPs, particularly where access to GPs is limited or too costly.

Third, funding of health services is split between the Australian and state and territory governments, which misaligns incentives and exacerbates the problems of fragmentation. In particular, the way funding is allocated, such as activity-based funding for hospitals, coupled with tight budgets and funding restrictions for PHNs that limit their activities, reduce incentives to collaborate.

These factors create considerable scope for greater collaborative commissioning in health care to improve the efficiency and quality of health services. While the activities and outcomes of regional collaborative approaches will vary, depending on each region's characteristics and needs, the goal is a better mix of care services, including better harnessing of primary care services to reduce preventable hospitalisations. As the Health Alliance, a joint initiative of Metro North Health and Brisbane North PHN (qr. 70, p. 2) noted, by having LHNs and PHNs work together 'we are able to jointly address the needs of people with chronic and complex conditions who often fall between the primary and acute care systems'.

Our focus on LHNs and PHNs, and how they partner with ACCHOs and other organisations, also builds on the findings from previous reviews, including the *Strengthening Medicare Taskforce Report* and the *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2025*. These reviews recommended that PHNs work with LHNs and ACCHOs, among others, to strengthen collaboration and integration (Australian Government 2023, p. 7; Huxtable 2023, p. 69). The NHRA mid-term review recommended developing a nationally consistent governance framework to drive and enforce integration between PHNs, LHNs and ACCHOs, along with minimum requirements for local planning and

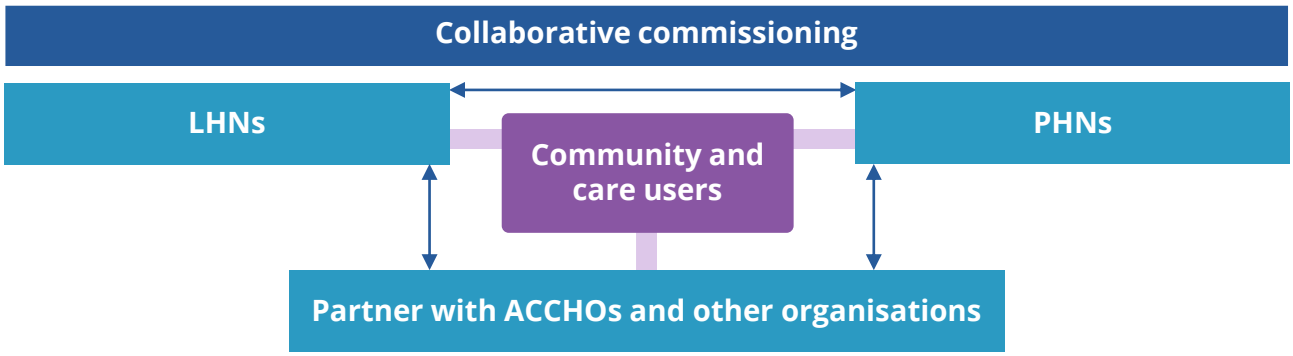
co-commissioning, shared and linked datasets, agreed programs of work and shared reporting and accountability outcomes.

The PC has previously reached similar conclusions about the need for greater collaboration between LHNs and PHNs, including in the *Shifting the Dial* productivity inquiry, the *Mental Health* inquiry, and the current review of the Mental Health and Suicide Prevention Agreement (2017b, p. 9, 2020a, p. 1134, 2025d, p. 93).

Reform of governance and funding to embed collaborative commissioning

Embedding systemwide use of collaborative commissioning requires a two-pronged approach. First, a more consistent approach to joint regional governance will enable better coordination and joint planning, clarity about roles and responsibilities, joint decision making where it matters, and accountability against shared outcomes. Second, these governance reforms must be accompanied by funding reforms that increase flexibility and incentivise and remove barriers to collaboration. Both reforms are necessary to realise the full potential of collaborative commissioning and overcome barriers to their realisation (figure 2.2).

Figure 2.2 – Embedding collaborative commissioning through governance and funding reforms will support more integrated care and better outcomes



Joint governance

- Joint needs assessments
- Agreed programs of work
- Joint monitoring and reporting of outcomes
- Supported by joint committees and data sharing arrangements

Funding

- Secure and flexible funding
- Adequate resourcing for joint governance
- Dedicated funding to expand integrated care
- Funding adjusted for meeting outcomes (the adjustment should initially target potentially preventable hospitalisations)

Outcomes

- Better outcomes for care users through access to more appropriate care and more seamless transitions between care services
- Shared knowledge that supports innovation and new models of care
- More efficient care through reduced duplication and services that better meet local needs and address gaps (including cost savings from reducing potentially preventable hospitalisations)

A consistent joint governance framework will enable more collaborative commissioning

Joint planning to guide collaboration

Strengthened joint planning processes would enable LHNs and PHNs to understand the priority needs of their population, plan the way in which they can collaborate and evaluate whether they are achieving intended care outcomes.

To varying extents, joint regional planning between LHNs and PHNs is already undertaken for mental health and suicide prevention services under the National Mental Health and Suicide Prevention Agreement. But approaches to this planning have been inconsistent, and in its interim report reviewing the Agreement the PC (2025d, p. 93) has recommended that national guidelines on regional commissioning and planning should be released by the end of 2025. Joint planning processes could be extended across all areas of mutual interest between LHNs and PHNs.

A joint needs assessment to identify priority needs

Identifying population health needs and service gaps is a critical first step in effective planning. This involves assessing the specific health needs of the region and how these might vary from national averages (for example, a particular region might have a relatively high population of frail and elderly residents, high rates of smoking, low rates of vaccination, and/or a significant population with a specific chronic disease). Further, it involves assessing how the health needs of those groups are currently being met. That is, where are the gaps in the current provision of services that mean people are not receiving the care they need, or are not being treated in the most timely and efficient manner (boxes 2.1 and 2.4 illustrate priority areas identified through needs assessments).

LHNs and PHNs commonly undertake their own health needs assessment or equivalent planning process, often for the same or overlapping areas. While each organisation's broader planning responsibilities extend beyond the scope of collaboration, adopting a joint approach that addresses areas of mutual interest has been shown to support a place-based and targeted approach to overall service delivery (Quigley et al. 2024).

LHNs and PHNs should work more closely together, in partnership with ACCHOs and other relevant organisations, such as local government. They should undertake joint needs assessments to identify the needs of their region and service gaps and duplications.

LHNs and PHNs already engage with Aboriginal and Torres Strait Islander organisations and representatives to varying extents. But there are still questions about how LHNs' and PHNs' partnership with ACCHOs could be formalised in a nationally consistent way. Partnership with ACCHOs must reflect their role as essential partners in program and service design and implementation and enable shared decision making. One option is that ACCHOs could lead regional needs assessments for Aboriginal and Torres Strait Islander people, but we are seeking input on the preferred approach (box 2.2).

One complication in establishing collaborative commissioning is that the boundaries between LHNs and PHNs generally do not align, despite the intent spelled out in the NHRA. There is also misalignment with the operating areas of other organisations, including ACCHOs, adding to complexity and meaning that collaborative arrangements will commonly need to be established with multiple different parties.

Box 2.2 – How should LHNs and PHNs partner with ACCHOs?

ACCHOs fulfill a vital role in delivering care services for Aboriginal and Torres Strait Islander people, and LHNs and PHNs need to consider their capability and the services they deliver early in planning processes. In other words, when undertaking joint needs assessments, LHNs and PHNs need to partner with ACCHOs (or other local Aboriginal and Torres Strait Islander health organisations or representative bodies) to better understand population health needs and existing services and gaps.

Under the National Agreement on Closing the Gap, governments have committed to four priority reforms: formal partnerships and shared decision making; building the community-controlled sector; transforming government organisations; and shared access to data and information at a regional level. Governments, LHNs and PHNs have an obligation to engage with ACCHOs as genuine partners in collaborative commissioning and to work alongside them to advance progress towards the priority reforms.

The Institute for Urban Indigenous Health (IUIH) has previously proposed that government should contract ACCHOs to provide needs assessments, separate from existing service delivery contracts, and that governments should be required to provide sufficiently disaggregated data (IUIH 2023, p. 19). IUIH considered that ACCHOs should lead regional needs assessments and service planning for the Aboriginal and Torres Strait Islander population because needs assessments by LHNs and PHNs lacked deep engagement with communities, whose needs were largely subsumed within broader population priorities.

Formalising the role of ACCHOs in leading regional needs assessments for Aboriginal and Torres Strait Islander communities should also support the objective of increasing the proportion of services delivered by Aboriginal and Torres Strait Islander organisations. These assessments could then inform the community-wide joint assessments undertaken by LHNs and PHNs. LHNs and PHNs could commission these needs assessments, but a more nationally coordinated approach might help provide consistency in coverage and progress the priority reforms.

An important consideration is how to ensure ACCHOs have the capacity to undertake these assessments and be equal partners in the process. ACCHOs vary in size, scope and geographical coverage and additional regional coordination between ACCHOs may be required. Flexibility will also likely be necessary – what works in one area may not be applicable elsewhere. In some instances, coordination at a state and territory level may be the preferred approach.

We are seeking input on the merits of this option and how it could be developed, or if there are preferable alternative approaches (information request 2.1).

The benefits of a joint needs assessment approach have been demonstrated in the United Kingdom, where the process has supported the identification of local health needs and a responsive approach to healthcare (Asmar et al. 2024, p. 12). Some organisations in Australia have already adopted a joint needs assessment approach, including those developed under the Queensland-Commonwealth Partnership (QCP) (box 2.3) and through the NSW Collaborative Commissioning program (box 2.1). The Central Coast Health Alliance, which includes the Central Coast Local Health District and Hunter New England and Central Coast PHN, has also developed a joint strategic needs assessment (Quigley et al. 2024). The Australian Healthcare and Hospitals Association (2023, p. 19) has also recommended joint regional needs assessments to support the move towards better use of data and reporting in an outcomes-focused, value-based healthcare system.

Box 2.3 – The Queensland-Commonwealth Partnership

The Queensland-Commonwealth Partnership (QCP) is a shared commitment from partners across Queensland to move towards an integrated, patient-centred and equitable health system. Organisations involved include Hospital and Health Services (HHSs), PHNs, ACCHOs and inter-jurisdictional government partners: the Queensland Department of Health and the Australian Government Department of Health, Disability and Ageing. The partnership features joint regional needs assessments, shared data, joint planning and the development of an accountable governance framework. Legislative reform has also recognised the Queensland Aboriginal and Islander Health Council, IUIH and Queensland PHNs as prescribed entities governing Queensland Health data.

Through the QCP, joint regional needs assessments have replaced HHS and PHN's respective individual needs assessments and a framework has been co-designed, providing a basis to identify shared priorities and inform opportunities for collaborative commissioning. The framework sets out four common phases: establishing the geographic region, governance and engagement plans; collecting and analysing data and conducting engagement; validating and triangulating data; and prioritising health and service needs and assigning lead agencies. The framework also features data requirements and provides flexibility for regions to select locally relevant outcomes.

Source: Impact Co. and QCP (2024a, p. 16); QCP (2024); Queensland Health (2024).

The QCP approach to a joint regional needs assessment appears to provide a good model that could be extended to all states and territories, noting that some flexibility will be required since the boundaries of LHNs and PHNs align differently across jurisdictions.

Joint needs assessments should incorporate the following features:

- identify and prioritise areas of need, clarify responsibilities, and identify which agencies may be best placed to act in each area
- highlight areas of overlapping or shared responsibility, creating opportunity for more coordinated planning and reduced duplication
- form a single document between the commissioning organisations
- be made publicly available in a timely manner, supporting transparency and accountability by being submitted to the relevant state and territory jurisdiction and the Australian Government Department of Health, Disability and Ageing.

Developing an agreed program of work

While a joint needs assessment can help to identify priority areas for action, the way these needs and gaps are addressed must be coordinated. That is, the commissioning organisations should develop an agreed program of work that addresses identified needs, including through the collaborative commissioning of new programs (which could include the types of programs illustrated in boxes 2.1, 2.4 and 2.6).

Under the current approach, responses are often developed independently and may be ad hoc. A coordinated approach, by contrast, can improve both accountability and outcomes. An agreed program of work should reflect local priorities and outcomes to be targeted and consider the constraints and priorities of the participating organisations. The work program should also consider the planned work of ACCHOs and other organisations. An example of this whole-of-system approach to planning is that developed by the South West Primary Health Care Alliance (box 2.4).

The agreed program of work should outline procurement processes for collaboratively commissioned services, including the funding source(s) and the roles and responsibilities of relevant organisations. Arrangements are likely to vary depending on the service/s being commissioned – some may involve joint or pooled funding, but this is not essential. Similarly, the level of involvement of ACCHOs in co-designing or leading the commissioning process will vary, depending on the nature of programs.

Box 2.4 – South West Primary Health Care Alliance

The South West Primary Health Care Alliance seeks to deliver whole-of-system governance for integrated primary care throughout South West Queensland. It is a partnership between the Western Queensland PHN, South West Hospital and Health Service (HHS), Cunnamulla Aboriginal Corporation for Health, Charleville & Western Areas Aboriginal & Torres Strait Islanders Community Health, Goondir Health Services and other regional partners. The partnership outlines clear roles and responsibilities, whole-of-system planning and pooled funding, as principles to support its vision. An Alliance Leadership Team with representatives from member organisations decides upon the Alliance's joint objectives, scope and work plans.

The Alliance developed a Workforce Implementation Plan Strategy to reverse the decline in the region's permanent GP workforce, identify gaps in primary care services and enable digital interoperability.

Collaborative relationships in the area have supported other partnerships, including the Nukal Murra Alliance, between four ACCHOs and Western Queensland PHN, and the preparation of Joint Regional Needs Assessments in 2024, between Western Queensland PHN and constituent HHSs. The Joint Regional Needs Assessments follow the QCP framework, where, for example, South West HHS and Western Queensland PHN identified 14 health and 38 service needs for their local community, prioritised into three tiers. The identified needs, including healthcare needs for an ageing population and culturally appropriate child and maternal services, benefit from whole-of-system planning and the delivery of integrated care.

Source: South West Hospital and Health Service (2025); South West Queensland Primary Health Care Alliance (2024); Western Queensland PHN (2025a, 2025b, p. 5).

Joint monitoring and reporting of outcomes

A clear and robust outcomes framework will support commissioning organisations to benchmark their performance, learn from their experiences and improve outcomes. This framework should involve LHNs and PHNs agreeing on intended outcomes, what success looks like and how it will be measured, consistent with national reporting frameworks.

Evaluating the success of joint regional health systems and integrated initiatives is highly complex (Crocker et al. 2020, p. 7; Impact Co. and QCP 2024b, p. 79). However, jurisdictions that have undertaken collaborative commissioning for some time have identified the importance of a joint outcomes framework. For example, The King's Fund and Nuffield Trust (Goodwin et al. 2012, pp. 8, 12–13) advocated that the UK National Health Service adopt a single outcomes framework to support joint initiatives between health bodies and steps have been underway to align the different outcomes frameworks (UK Department of Health 2014).

Commissioning organisations should also have consistent processes in place for monitoring and reporting against the agreed outcomes framework. This approach supports transparency and accountability and enables successful new initiatives to be identified. It will also be essential to inform the funding adjustment proposed below. While approaches and programs will vary, reporting should enable nationally consistent

comparisons. For that reason, it should draw on national reporting frameworks, including the Australian Health Performance Framework[7], which is designed to support system-wide reporting of health and health care performance and the Aboriginal and Torres Strait Islander Health Performance Framework.

Support joint planning through joint committees and better data sharing

Joint committee arrangements

Stronger joint planning arrangements should be underpinned by formal engagement processes that establish ownership and accountability. Under the National Health Reform Agreement, LHNs and PHNs are expected to have overlapping board composition and establish formal engagement protocols, but these expectations are not having enough effect. The NHRA mid-term review identified a lack of requirements for formal participation by PHNs with LHNs or for planning and implementation structures, with the quality of collaborative practices varying as a result (Huxtable 2023, p. 67).

Joint committees should be formed to oversee collaborative commissioning activities. The scope of these committees should include responsibility for overseeing joint needs assessments and planning, and for oversight, coordination and monitoring of collaboratively commissioned programs. These committees should meet regularly and report to their respective boards and executives.

These types of arrangements have been recommended before – in position papers written as part of a NSW agreement between NSW Health, NSW PHNs and the (then) Australian Government Department of Health and Aged Care, for example (NSW/ACT Primary Health Network Executive Office 2023). And, under the NSW Collaborative Commissioning initiative, Patient Centred Co-commissioning Groups were formed by LHDs and PHNs to take joint responsibility for improving care in their communities. Each group would determine its own governance model, co-design care pathways and determine how to implement them, including the types of services to commission (NSW Health 2024b).

In addition to LHN and PHN members, these committees should include representatives of ACCHOs, other care sectors, service providers and relevant independent experts, where practicable. The South West Queensland Primary Health Care Alliance Leadership Team includes representatives from a wide range of key partners in the region (box 2.4). When forming these committees, the organisations' other consultative committees and arrangements should also be considered.

Better data sharing

Data sharing between commissioning organisations is essential to support the development of joint needs assessments, to assess the effectiveness of commissioned programs, and to undertake many collaboratively commissioned services. But current data sharing is inconsistent, and where it does occur, takes significant time and resources to establish. The PC has heard of substantial barriers to sharing and accessing data, even within organisations, due to technical constraints, and privacy and other concerns.

The importance of data sharing in successful collaborative commissioning has been evident through the Queensland-Commonwealth Partnership (box 2.3) and the NSW Collaborative Commissioning initiative. For example, data analytics supported by the Lumos program links de-identified data from general practices with other health service data to build an evidence base about patient pathways (NSW Health 2024a).

The recommendations of the NHRA mid-term review identified the need for data sharing, including linked datasets on population and service utilisation at the local level, where possible (Huxtable 2023, p. 69). The PC understands that the next addendum to the NHRA will progress data sharing initiatives. With adequate

[7] This framework is currently being updated by the Australian Institute of Health and Welfare.

resourcing, they will be important to facilitate more collaborative commissioning and integration across the care sector, as well as innovation in the delivery of care that improves productivity and outcomes.

Information request 2.1

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

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

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

Funding should provide certainty and flexibility

Funding to PHNs should support programs of varying lengths …

To embed collaborative commissioning, PHNs require secure, longer-term funding, accompanied by periodic review. The Salvation Army (qr. 24, p. 3) submitted that 'short-term funding agreements and design periods are not conducive to developing robust service delivery frameworks which provide the most effective assistance'. Moreover, funding cycles should allow some carry over of unspent funds, to reduce the potential for wasteful spending.

Funding cycles should also be long enough to allow program evaluation. The Royal Australian College of General Practitioners (2025b, p. 8) noted that 'short-term funding, coupled with the need for project/program evaluations within these short timeframes, limits the kind of programs that can be run to those that can demonstrate measurable results quickly.' Short-term funding is a key barrier to PHNs investing in longer-term programs. An anonymous PHN noted that:

> … when there's less than 6-months left [on the contract] … staff start to leave. … The longer you leave it, the more they start leaving, the bigger the dip [in service delivery] is. … as you re-fund them, it takes probably an equal time plus about 50% to get back up to where you were before … (Bates et al. 2022, p. 588)

… and funding should be flexible to allow for more collaborative commissioning

LHNs and PHNs need some flexibility to collaboratively commission services that meet local needs, but current funding arrangements limit what they can do (NSW Health 2025). PHNs' funding is generally not flexible, affording them little scope to collaborate with LHNs or ACCHOs in purchasing care services. Moreover, there are limits on what PHNs are authorised to commission, and while the PHN grant guidelines emphasise flexibility, the experience of PHNs can differ. An anonymous PHN stated:

> [The funding is] fairly much ring-fenced. So [national] priorities need to become the PHNs priorities. … I think our stakeholders don't realise how little of our funding is actually funding that we are able to use flexibly. (Bates et al. 2022, p. 588)

Current PHN funding arrangements can also impact ACCHOs:

> … when funding is provided to ACCHOs through PHN commissioning arrangements, its value is often diminished due to … lack of flexibility in how the funding can be utilised … (NACCHO, sub. 32, p. 9)

The Australian Government should provide PHNs with enough flexibility to commission services targeting local priorities arising from the needs assessment. This principle should be applied to new funding for PHNs (discussed below) and to other categories of funding where appropriate (see the PC's review of the National Mental Health and Suicide Prevention Agreement). Breadon et al. (2022, pp. 4, 61) have similarly recommended giving PHNs more flexibility to reflect their broad role beyond specific programs.

LHNs should also have enough flexibility to collaborate. Service agreements with state and territory governments should not unduly constrain their activities. Similarly, legislative barriers should be removed so that LHNs can direct funding to collaboratively commissioned services. For example, LHNs should be able to direct funding to collaboratively commissioned services in primary care, including to manage patients with chronic conditions or engage in prevention activities. LHNs are effectively precluded from funding or commissioning GPs as Medicare payments are not available when a service is delivered by a state agency such as an LHN (PC 2017a, p. 63).

Greater funding flexibility will afford the Australian Government Department of Health, Disability and Ageing less control over how funding is used and which parties the PHNs can collaborate with. However, with the right incentives and accountability mechanisms in place, greater flexibility should produce better outcomes.

Dedicated funding may also be required

Funding for joint governance and planning

The joint governance arrangements proposed above will formalise or replace many existing practices that are already resourced by LHNs and PHNs. In addition to existing activities, LHNs and PHNs would be required to undertake joint planning and needs assessments, participate in joint collaborative commissioning committee arrangements and implement data sharing arrangements. As a result, some additional funding may be necessary to effectively undertake the proposed joint governance initiatives.

The need for additional funding was supported by the Health Alliance in its questionnaire response:

> Developing and delivering joint commissioning activities also takes time and effort. … [and] needs to be appropriately resourced across the commissioning cycle … (qr. 70, p. 4)

ACCHOs and other Aboriginal and Torres Strait health organisations or representative bodies will also need sufficient funding to undertake planning processes with LHNs and PHNs. The size of any additional funding and how it is allocated or administered will depend on how partnership arrangements operate.

In setting appropriate funding, the Australian Government should consider the need to build capability (Health Consumer's Council WA, qr. 48, p. 4). Training and support policies to upskill LHN and PHN staff across the areas of leadership, co-design practices and data capability should be adopted.

Dedicated funding to address gaps in services

In addition to more flexible, longer-term funding and support for planning, LHNs and PHNs should be able to access dedicated Australian Government funding – either new or reallocated – if they submit their joint needs assessment and an agreed program of work identifying the shared outcomes they are seeking to address through collaborative commissioning programs. To access dedicated funding, these outcomes should clearly link to reducing future costs through better health outcomes or reduced PPHs.

The dedicated funding should be divided between LHNs and PHNs in a ratio that reflects the division of responsibility outlined in their joint needs assessment and agreed program of work. We are seeking further input on what quantum of funding would be sufficient to enable meaningful collaboration.

The case for dedicated integrated care funding has been argued previously, including in the PC's *Shifting the Dial* (2017b, p. 9) and by the Royal Australian College of Physicians (qr. 64, p. 5) which suggested establishing 'joint funding pools … to support integrated care'.

This funding would enable better-targeted care services that improve outcomes for the community. It is also a good strategic investment. It would enable more efficient use of funding by tailoring services to needs, reduce the need for more costly services (such as treatment in hospital emergency departments) and ease pressure on growing health care costs.

Funding should be adjusted for meeting outcomes

To direct funding towards successful and cost-effective collaborative commissioning programs, the quantum of dedicated funding should be adjusted based on the success of the collaborating organisations in meeting their shared outcomes. This approach would incentivise effective collaboration and enable ongoing funding for successful programs, while also providing an accountability mechanism that encourages innovative and localised approaches and would curtail expenditure on ineffective programs.

A current barrier to collaboration between LHNs and PHNs is the misalignment between who funds an initiative and who benefits from its outcomes – the 'wrong pocket problem' (McCullough 2019, p. 1). For example, a PHN that funds a primary care initiative that reduces hospitalisations does not benefit from saved bed days and other resources. However, if LHNs and PHNs can share the benefits from achieving their objectives, they are more likely to collaborate on effective programs.

The funding adjustment could initially target potentially preventable hospitalisations

The shared outcomes framework will be central to the funding adjustment, enabling benchmarks to be set and determining whether they are met. While the framework is likely to set out a range of local goals, we propose initially basing the funding adjustment on whether LHNs and PHNs meet their targets for reducing PPHs. This measure could be a launchpad into other health outcome measures that reflect integrated care and local needs.

PPHs numbered about 778,000 in 2023-24 and represent a large part of Australia's preventable health expenditure (AIHW 2025b). The age-standardised rate of PPHs for Aboriginal and Torres Strait Islander people increased between 2013-14 and 2018-19 from 63 to 75 PPH per 1,000 population (AIHW 2025a).

To convey the size of the cost of PPHs, the Australian Institute of Health and Welfare estimated that in 2021-22 they produced an average length of stay in hospitals of 3.9 days, or almost 10% of all hospital bed days – a significant portion of the $85.6 billion spent on public hospitals (AIHW 2024d, 2025c).

PHNs already have a key role in addressing PPHs, reflected in their performance criteria (ANAO 2024, p. 93; Huxtable 2023, p. 76). The NHRA states that the Australian Government will commission services in regions through PHNs as part of its ongoing investment in 'programs designed to minimise the impact of potentially preventable hospital admissions arising from shortcomings in areas within its own direct policy control' (FFR 2020, p. 74).

The funding adjustment should be carefully designed. Some factors that cause PPHs are outside the control of LHNs and PHNs. For example, hospital exit blocks caused by poor availability of aged care or disability services can lead to discharge delays and more PPHs (Huxtable 2023, p. 71).

Demographic and socioeconomic factors, such as the age and income of the local population, or regional differences in the health of populations, can also contribute to PPHs (box 2.5). LHNs and PHNs should not be penalised or rewarded based on the risk profile or needs of their population. Design of the funding

adjustment could also consider factors such as the timeframe over which outcomes are measured and the size of the adjustment relative to funding levels of the recipient.

Box 2.5 – Potentially preventable hospitalisations vary by area

PPHs vary by region, partly reflecting regional differences in the health of populations. For example, in 2021-22 the age-standardised rates of PPHs were about three times larger in Western Queensland than in Northern Sydney (4,800 to 1,600 per 100,000 people) (AIHW 2024d).

The types of PPHs also vary across regions. They are classified in three categories.

- Hospitalisations due to diseases preventable by vaccination, such as influenza, measles and whooping cough.
- Acute conditions with a usually a quick onset that may not be preventable, but theoretically would not result in hospitalisation if timely and adequate care were received in the community. This includes conditions such as dental conditions, urinary tract infections, and ear, nose and throat infections.
- Chronic conditions that may be preventable through lifestyle change but can also be managed in the community to prevent worsening of symptoms and hospitalisation. This category includes conditions such as diabetes complications, chronic obstructive pulmonary disease and asthma.

Victoria and Tasmania have similar overall rates of PPHs (24.2 and 25.9 per 1000 people), but PPHs in Tasmania from vaccine-preventable conditions are only 1.0 per 1000 people compared to 1.6 per 1000 people in Victoria in 2022-23. Chronic condition PPHs are 14.6 per 1000 people in Tasmania compared to 11.9 in Victoria. These figures underscore the importance of place-based programs that can best address the specific health challenges in a local area.

Source: AIHW (2024d); SCRGSP (2025c).

Financial incentives of this nature have precedents. The review of the NHRA recommended that it should 'prioritise the development of optimal models of care, using agreed innovative financing mechanisms' to shape demand for health services, such as PPHs (Huxtable 2023, p. 78). And recent funding and pricing reforms have introduced incentives for public hospitals to reduce hospital acquired complications.[8]

The PC welcomes inquiry participants' feedback and ideas about the proposed funding adjustment, including how it could be implemented (information request 2.2).

[8] In 2017, IHACPA introduced a funding approach for sentinel events, whereby a national weighted activity unit (NWAU) of zero was assigned to episodes of care which include a sentinel event. In July 2018, IHACPA introduced a funding adjustment for hospital acquired complications (HAC) whereby funding is reduced for any episode of admitted acute care where a HAC occurs. The reduction in funding reflects the incremental cost of the HAC, which is the additional cost of providing hospital care that is attributable to the HAC. In July 2021, IHACPA introduced a funding adjustment for AHRs, whereby each patient episode is assigned a complexity group – low, moderate or high – on the basis of the patient's risk of readmission. The final NWAU is calculated by multiplying the funding of the readmission by the risk adjustment for the complexity group. The total is then subtracted from the funding of the index (or initial) admission (IHACPA 2025).

Reform will expand the benefits of collaborative commissioning beyond pilots and isolated initiatives

The reform is intended to enable LHNs and PHNs to work together to overcome gaps and service fragmentation and, ultimately, reduce PPHs. While its net benefits are hard to quantify – they will depend on the specific initiatives of LHNs and PHNs – literature and case studies can provide a guide (box 2.1). Collaborative commissioning programs will by design vary in their characteristics and effects between regions, but to provide an indication of the benefits from expanding collaborative commissioning across the country, we estimated that the national scaled-up equivalent of some existing collaborative commissioning programs could generate annual savings of about:

- $145 million for the Aged Care Emergency service (in the Hunter New England Central Coast PHN)
- $125 million for the Care Collective program (in the Brisbane North PHN)
- $280 million for the Frail and Older People program (in the Northern Sydney PHN).

These estimates should be interpreted with caution as they do not consider varying workforce capacities and capabilities, LHN-PHN relationships, the cost of delivering care and the underlying health needs of PHN catchment populations across Australia.

Another approach to measuring the benefits is to consider the hospitalisations that could be avoided through collaborative commissioning. As above, PPHs are responsible for about 10% of Australia's approximately 34 million bed days (AIHW 2024d, nd). Assuming PPH bed days cost the same as bed days for other hospitalisations, a modest 10% reduction in PPHs through greater collaboration could save about $600 million a year (PC estimates based on AIHW 2025c).[9]

Collaborative commissioning can also yield benefits beyond the freeing up of resources in the health system. Ten million Australians live with a chronic health condition; more than two million have two or more chronic conditions (PC estimates based on 2021 ABS Census). A healthier population will lead to increased workforce participation and labour productivity for both patients (Verikios et al. 2015) and carers.

Importantly, the reform will be crucial for addressing health needs in Aboriginal and Torres Strait Islander communities. It is essential that LHNs and PHNs work with ACCHOs to reduce PPHs for Aboriginal and Torres Strait Islander people. It will also contribute to progress towards achieving targets in the National Agreement on Closing the Gap, including Outcome 1 (long and healthy lives) and Outcome 2 (babies of a healthy birthweight). IUIH's Birthing in Our Communities program (box 2.6) provides an example of where collaboration has led to better health outcomes for Aboriginal and Torres Strait Islander people.

This reform gives LHNs and PHNs an incentive to innovate. While progress might be gradual, these innovations can be disseminated as the evidence base grows. For example, they may lead to greater uptake of digital technology – and in particular AI – to improve integrated care (PC 2024c).

Further, the benefits of the reform are likely to increase over time. To date, collaborative approaches have usually been small scale and ad hoc. The reform seeks to develop an ecosystem that draws on the benefits of collaboration to enable greater uptake of effective interventions across the country. Ultimately, demonstrated success could expand the footprint of these activities relative to other forms of health spending, such as emergency or acute admitted services, or beyond healthcare into aged care and disability.

[9] The average cost per hospital bed day is approximately $2,500 (PC estimates based on AIHW 2025c).

Box 2.6 – Birthing in Our Communities

Culturally safe and appropriate antenatal health services are paramount to ensuring Aboriginal and Torres Strait Islander children are born healthy and strong. The Birthing in Our Communities (BiOC) program is a unique model of Indigenous-led maternity care that provides culturally informed maternal and infant health services for Aboriginal and Torres Strait Islander families. The initiative is a partnership between the IUIH, Metro South HHS, Mater Health Service and private health services. The program features Aboriginal and Torres Strait Islander governance and oversight through a steering committee and integrated service delivery with public and private health services.

BiOC has proven to perform better than standard care on a range of national maternity indicators and has closed the gap in preterm births and birth weights, with one study estimating a 5.3% reduction in preterm births for Aboriginal and Torres Strait Islander families through the BiOC program, relative to standard care. In addition, the program costs less than standard care, with estimates of a cost saving of $4,810 per mother-baby pair.

The program contributes to progress toward Outcome 2: Aboriginal and Torres Strait Islander children are born healthy and strong and Priority Reform Two under the National Agreement on Closing the Gap*:* a strong and sustainable Aboriginal and Torres Strait Islander community-controlled sector delivering high quality services to meet the needs of Aboriginal and Torres Strait Islander people.

Source: Gao et al. (2023); IUIH (2023, p. 15); PC (2024b, p. 24).

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?

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?

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

Implementation should commence immediately

Negotiations on the NHRA provide an immediate window

The NHRA is the key lever for embedding collaborative commissioning between LHNs and PHNs because it presents an opportunity for Australian and state and territory governments to jointly commit to reform. The ideas proposed in this report are consistent with the intent and ambition of the NHRA as it stands.

But the existing agreement falls short because it is aspirational, with insufficient detail and accountability to achieve tangible progress on collaboration between different parts of the health sector.

The current negotiations on the next addendum for the NHRA enable governments to move quickly to implement reform. The mid-term review of the NHRA recommended the establishment of a national governance framework as part of the next agreement. The reform proposal in this report is broadly consistent with that recommendation and builds on it.

The next addendum needs to be more prescriptive.

- The requirements for strengthening joint governance, including joint needs assessments, planning and reporting, and joint committee arrangements should be spelled out to provide clear expectations of how LHNs and PHNs will partner with ACCHOs and other organisations.
- Funding changes, including specific funding for integrated care, and the funding adjustment for LHNs and PHNs that reduce PPHs, should be included in the addendum.

Governments need to provide support and guidance

While the next addendum to the NHRA should be more detailed and prescriptive, governments may also need to provide additional guidance to inform how collaborative arrangements would work in practice.

This guidance could expand on the approach in the National Mental Health and Suicide Prevention Agreement, where governments agreed to develop national guidelines on regional commissioning and planning, although as noted earlier these have not been released (PC 2025d, pp. 92–93).

To support broader collaborative commissioning between LHNs and PHNs, stronger national guidelines and tailored state and territory-based partnerships may be needed. National guidelines for health regional commissioning and planning, focusing on LHNs, PHNs and ACCHOs, would provide clarity and consistency to enable more effective commissioning capability. In tandem, partnerships between the Australian, and state and territory governments (where they don't exist) should be formed, with guidance and approaches across jurisdictions tailored to reflect different arrangements, strategic priorities and current initiatives.

State and territory health departments will play a key role in leading change. They should provide direction and leadership to LHNs to embed collaboration with PHNs, ACCHOs and other key partners. They need to build on the lessons from initiatives to date (such as the NSW Collaborative Commissioning program and the Queensland-Commonwealth Partnership) to embed collaboration between Australian, state and territory agencies, and with local place-based decision makers.

Local decision makers need to be empowered

This reform can create tension between decision making, governance and resourcing at the local level, and at the national or state and territory level. Given the top-down nature of funding and political accountability, policy makers can be reluctant to cede decision making to local organisations. A lack of confidence in their capability and accountability may be amplified by the absence of a clear outcomes framework against which organisations can report.

Regional bodies need to be set up for success as trusted and accountable local decision makers. International evidence indicates that regional or place-based approaches that largely devolve decision making, responsibility and accountability, such as that of the UK National Health Service, are effective and improve outcomes (The King's Fund 2020). In Australia, the establishment of the community-controlled Cape and Torres Health Commissioning exemplifies an approach intended to cede control and enable place-based

decision making while building local organisational capability and accountability and supporting a foundation of trust. The reforms discussed above seek to advance this objective.

Collaborative commissioning is a key piece of the reform puzzle

Our proposed reform has potential to deliver better outcomes and more efficient care. But fully embedding joint governance arrangements and the development of new needs assessments will take time. The reforms will also need to align with other changes affecting the collaborating parties. In particular, changes that arise from the concurrent PHN business model review – initiated by the Australian Government Department of Health, Disability and Ageing in late 2024 – that might strengthen governance or increase flexibility should create and strengthen opportunities for collaboration between LHNs and PHNs.

Collaborative commissioning between LHNs and PHNs is just one part of the broader reform puzzle, and there is scope for more integrated care and collaborative place-based decision making across the care economy. Other reforms – such as changes to funding models so they are outcome rather than activity focused, or alterations to the way sectors of the care economy are administered – will also be required to maximise the benefits of these proposed reforms. The PC invites feedback on this draft proposal, including the draft recommendation above and the questions suggested in the information requests.

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?

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

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

3. A national framework to support government investment in prevention

Summary

Investment in prevention can produce significant benefits to individuals, government and the community, relative to its costs.

- High-quality prevention programs can generate social benefits such as reduced crime, longer and healthier lives, and improved educational outcomes. And the gains are often concentrated in the most disadvantaged communities. These improvements in outcomes can slow the escalating growth in government care expenditure. In short, investing in prevention can help deliver on today's care needs and priorities while reducing future costs.

Australian, state and territory governments have recognised the need for greater prevention efforts. But siloes within government, short-term budget and election cycles, and limited evaluations of preventive policies all pose barriers to government funding of prevention.

A National Prevention Investment Framework would support government investment in effective prevention programs to improve outcomes for individuals, benefit the wider community and reduce future demand for services. It will do this by:

- recognising that the benefits of prevention can take long periods of time to arise and do not necessarily align with government departments or tiers of government
- providing a robust assessment and evaluation process that enables governments to invest in effective programs that deliver long-term benefits.

Implementation of a National Prevention Investment Framework would involve:

- an independent and cross-sectoral Prevention Framework Advisory Board that assesses and provides expert advice on requests for prevention funding
- a funding mechanism that supports eligible prevention initiatives across Australian, state and territory governments
- agreements between Australian, state and territory governments to establish a commitment to co-funding prevention efforts and maintenance of existing prevention funding.

Draft recommendation

Draft recommendation 3.1
Establish a National Prevention Investment Framework to support investment in prevention, improving outcomes and slowing the escalating growth in government care expenditure

The Australian Government should work with state and territory governments to establish a National Prevention Investment Framework. The framework will support governments to invest in prevention programs that improve outcomes and reduce demand for future acute care services. It will identify programs that produce the best value for money, based on rigorous assessment and evaluation. The framework should provide a stable and ongoing basis for funding prevention, recognising that the benefits fall across sectors and levels of government, and over extended timeframes.

The framework should be implemented by establishing:

- an independent Prevention Framework Advisory Board that assesses and provides expert advice on requests for prevention funding and develops a standardised actuarial model and frameworks for the analysis of prevention programs. The board would evaluate ongoing prevention programs, recommend whether programs should continue to be funded, and build the evidence base for prevention
- a funding mechanism that supports eligible prevention initiatives across Australian, state and territory governments. The mechanism should support co-contributions from state and territory governments based on their expected benefits, enable consideration of the second-round and longer-term fiscal effects of prevention programs, and facilitate ongoing funding where needed
- an intergovernmental agreement between the Australian, state and territory governments that outlines prevention funding arrangements and the roles and responsibilities of relevant parties. The agreement should be accompanied by federation funding agreement schedules that deliver Australian Government funding to states and territories for specific interventions.

Investing in prevention can improve outcomes and care sector efficiency

Prevention reduces the risk of future problems or slows their development

Prevention means taking early steps to stop problems from starting or getting worse. These could include promoting healthy lifestyles to prevent illness, supporting young people to stay out of the criminal justice system or helping people build skills to avoid substance abuse. Prevention activities can:

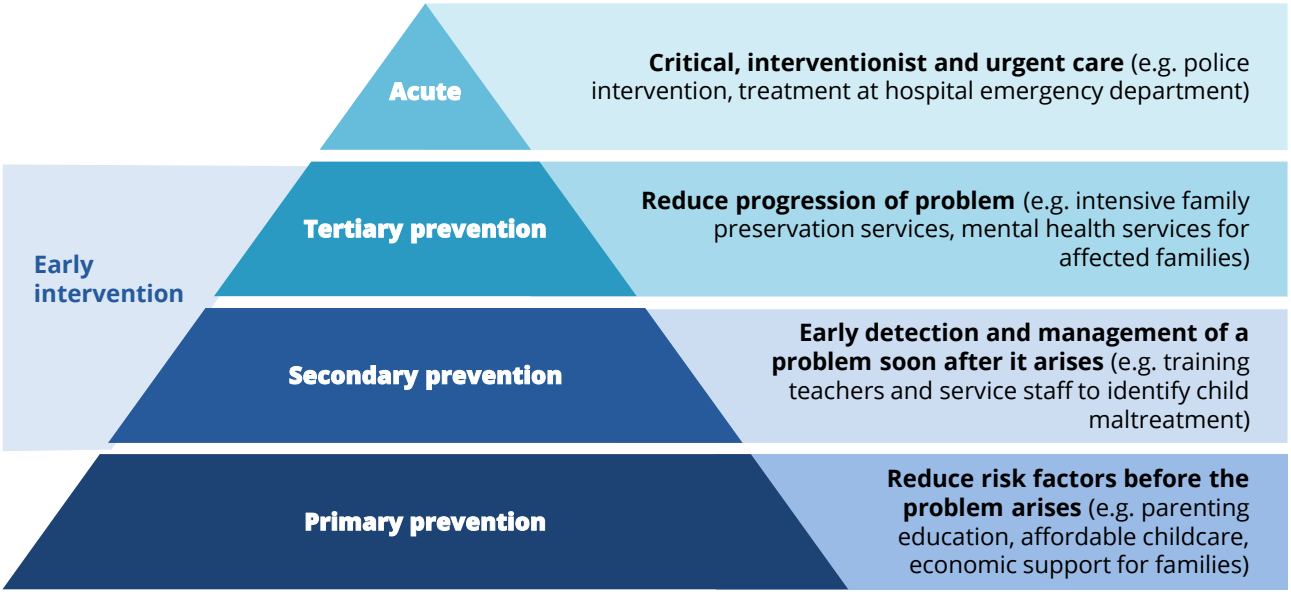
- reduce risk factors before problems arise (primary prevention)
- help detect issues early (secondary prevention)
- slow the progression of a problem during initial stages (tertiary prevention) (figure 3.1).

Acute services on the other hand respond to problems after they have intensified and require urgent, often costly actions, that can be associated with worse outcomes (for example, treatment at emergency departments or judicial interventions).

While prevention is often associated with population health, we take a broader view, and include interventions in areas like housing, education, justice and family support services, recognising that actions in one policy area may have benefits in others.

Figure 3.1 – Prevention and acute care lie on a spectrum[a]

Definitions and examples of prevention



a. Some publications use the phrase 'early interventions' to refer to interventions targeted towards children and/or adolescents specifically. We take a broader definition of the phrase and include interventions that are targeted towards adults. Early interventions are a subset of broader preventive interventions and can include both secondary and tertiary prevention.

Prevention improves quality of care through better outcomes

Prevention directly improves people's lives

A well-designed preventive intervention can improve wellbeing and support healthier and more productive lives. Depending on the intervention, benefits could include better health (longer life expectancy and reduced incidence and severity of disease), improved mental health, better educational outcomes, improved employment prospects, higher income and greater quality of life.

Many programs in Australia and overseas have demonstrated that investment in prevention has improved individual outcomes, often achieving benefits that acute services cannot produce.

- **Greater housing stability for people at risk of homelessness**: The Housing First model, which provides immediate, permanent housing alongside supports to address mental health, health and social needs, has been highly effective in providing stable housing for people with a history of homelessness. Evaluations across multiple countries indicate most participants are successful in sustaining housing (66-90%), often outperforming conventional approaches (Roggenbuck 2022, p. 1).
- **Reduced cancer rates and cancer-related deaths**: The SunSmart program, which involves community programs, mass media campaigns and advocacy relating to sun safe behaviour, is estimated to have prevented more than 43,000 skin cancers and 1400 skin cancer deaths in Victoria between 1988 and 2010 (Shih et al. 2017, pp. 371, 374). Similarly, tobacco control initiatives such as tobacco taxation, bans on tobacco advertising and anti-tobacco mass media campaigns are estimated to have prevented 78,925 deaths in Australia between 1956 and 2015 (Luo et al. 2019, p. 208).

- **Reduced child maltreatment**: International and Australian evidence demonstrates that a range of counselling and educational interventions can reduce incidents of child abuse and neglect (Dalziel and Segal 2012; Stout et al. 2022; WSIPP 2024). For example, an Australian home visiting program for high-risk teenage mothers has been linked to reduced adverse outcomes including infant death, severe non-accidental injury of the infant and non-voluntary foster care (which stems from substantiated risk of child abuse and neglect, or the mother's imprisonment) (Quinlivan et al. 2003).

Prevention also benefits the wider community

The benefits of prevention do not just accrue to people who are targeted but can generate spillover benefits such as reduced future service and support needs, reduced crime, improved labour productivity, higher employment, and better social cohesion.

For example, participants who experienced increased housing stability due to the Housing First programs highlighted, experience fewer hospitalisations and emergency department admissions and in some cases, less incarceration, reducing pressure on these services (Roggenbuck 2022, pp. 23–25). Similarly, the prevention of chronic health conditions like cancer can lead to economic benefits from increased labour force participation and productivity and reduced healthcare costs (OECD 2024, pp. 65–82).

Targeted prevention programs can also result in greater benefits to people from low socioeconomic backgrounds. The Early Years Education Program, an Australian program targeted towards children experiencing social disadvantage and significant family stress, led to improved IQ and language development (Tseng et al. 2022, p. 5). Three years after entering the program, participants' scores had improved to the point where they no longer differed significantly from the population average. Evaluations of similar targeted early childhood initiatives in the United States, like the Perry Preschool Project and the Abecedarian Project, suggest that the benefits for disadvantaged children can persist well into adulthood through better employment and education outcomes (Campbell et al. 2012; García et al. 2021).

Prevention can make the care sector more efficient

In many cases, preventing a problem from developing can be a more efficient use of resources than addressing it after it happens. Prevention programs can deliver more value than their total cost (positive net benefits), can limit the need for higher cost acute and intensive services and supports while achieving the same results (more cost-effective), and, in the best cases, can achieve better outcomes while reducing costs (cost-saving) (box 3.1) (Vos et al. 2010; WSIPP 2024). For example, some obesity prevention measures can simultaneously promote health and save money (Ananthapavan et al. 2020).

More efficient use of limited government resources in the care sector is increasingly important for ensuring long-term budget sustainability. The *Intergenerational Report 2023* projects that Australian Government expenditure associated with some key areas of the care sector – health care, the National Disability Insurance Scheme, and aged care – will increase from 6.2% of GDP in 2022-23 to around 10.8% in 2062-63 (Commonwealth of Australia 2023a, pp. 170–180). Investing in effective prevention has the potential to slow expenditure growth by allocating resources to programs that will reduce demand for care services in the future (figure 3.2).

Box 3.1 – Cost-effectiveness, cost-benefit analysis and efficiency

Improving efficiency involves making the most of limited resources to boost overall wellbeing. Removing barriers to government investment in prevention can:

- improve allocative efficiency by redirecting funding toward prevention programs that deliver greater value for money
- enhance dynamic efficiency by supporting long-term investments that reduce future demand for high-cost services and supports. The relative benefits of a suite of different interventions can be assessed by economic methods such as cost-effectiveness and cost-benefit analysis.

Cost-effectiveness analysis compares programs seeking the same outcome to identify which program can deliver that outcome for the lowest cost. This approach helps distinguish between:

- **cost-saving programs**, that improve outcomes (like better health or reduced dependence) and reduce overall spending. Cost savings can happen at the individual level (for example, a person needs less care in the future) or at the system level (for example, the government spends less overall on services and supports). Individual-level savings do not always add up to savings for the whole system. For example, freed-up resources (like care workers or hospital beds) may be quickly taken by others on waitlists, meaning that overall costs may remain similar while overall outcomes improve
- **cost-effective programs** achieve the desired outcome at an acceptable cost, even if it means spending more overall. They might not save money but still offer good value for the community. Replacing a less cost-effective program with a more cost-effective program can still lower overall spending.

Cost-benefit analysis tallies the monetary value of all outcomes and inputs involved in a particular program. This method is especially useful for valuing programs with broader effects across a range of outcomes including benefits to the government (lower long-term service and support costs, increased tax revenue), individuals (better health, higher income, improved quality of life) and community (lower crime rates, stronger social ties, better wellbeing overall). If a program's total benefits are greater than its costs, it is said to have a positive net benefit.

The *Assessing Cost-Effectiveness in Prevention* report identified numerous cost-saving preventive interventions in Australian health care. These were estimated as able to deliver significant health gains and, despite costing the health sector $4.6 billion, they were estimated to generate $11 billion in avoided healthcare costs over the lifetime of the 2003 population (Vos et al. 2010, p. 66).[10] Directing resources to cost-saving prevention not only improves outcomes but also frees up funds for other uses, increasing the overall benefit society receives from a given set of resources.

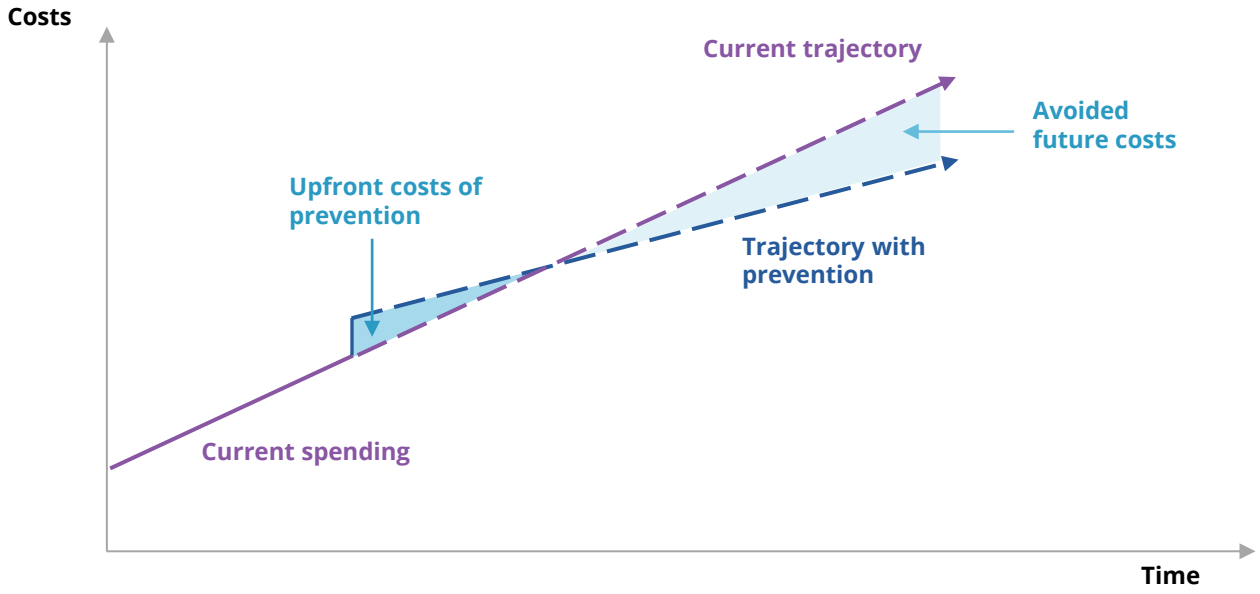
The development of linked administrative datasets and machine learning and AI tools could further increase gains from prevention by better targeting cohorts with a higher likelihood of requiring future government assistance. Examples of the use of administrative datasets for targeting prevention programs include social investment planning by New Zealand's Social Investment Agency (NZ SIA 2017), the NSW Government's

[10] Part of the difficulty with prevention is demonstrating the 'real' benefits that arise from preventive efforts. While effective prevention may reduce consumption of services by those targeted by an intervention, any freed-up resources are often used to provide services to others while any fixed costs will continue to be incurred (PC 2021).

Forecasting Future Outcomes report (Taylor Fry 2018) and the Department of Social Services' Priority Investment Approach (AGA 2022). In the UK, AI-based prediction tools have been used to identify elderly patients in community care at high risk of falls, leading to a 20% reduction in fall incidents and reducing hospitalisations and costs while improving the quality of life of the people involved (Heger et al. 2024).

Figure 3.2 – Prevention can dampen the current trajectory of care costs

Illustration of how investment in prevention programs can affect overall care costs



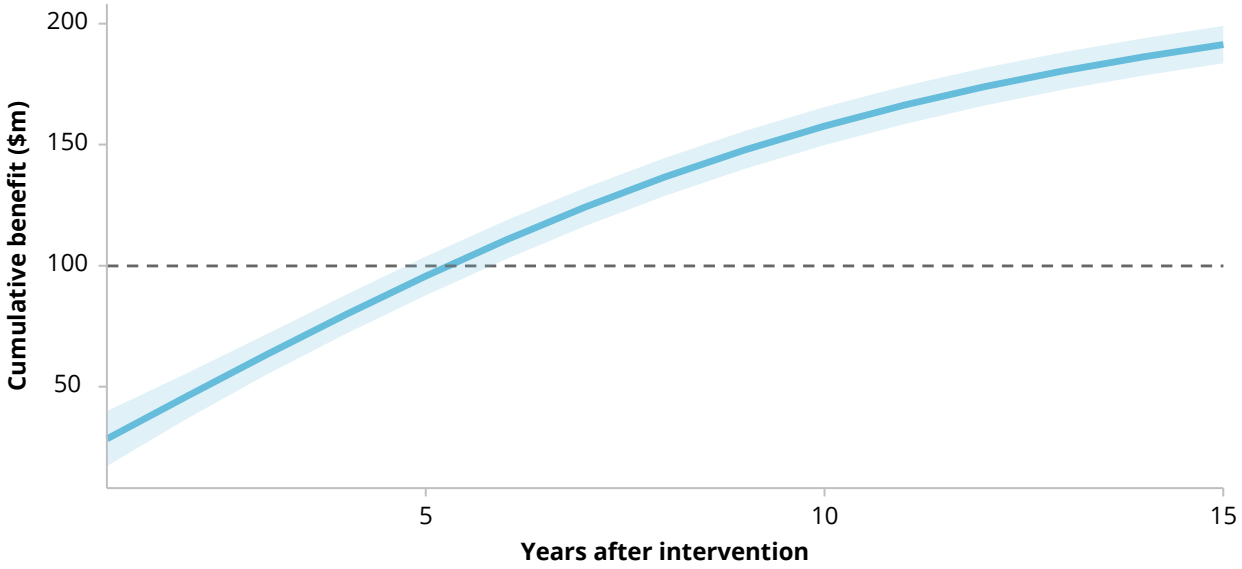
… and the potential gains are large

Benefits from prevention are potentially substantial, both for governments and people that benefit directly. But they can accrue over a longer timeframe than governments usually budget for. Depending on the return on investment and the rate at which future benefits are discounted, a bundle of effective prevention programs can return a net benefit after about six years (figure 3.3).

Estimating overall expected net benefits from a suite of preventive actions is complex. It depends on the amount of investment, the expected return (the monetary value of the total net benefits relative to the cost of the intervention) and the timeframe over which that return is realised. For example, an initial investment of $100 million into an illustrative portfolio of evidence-based prevention programs could generate approximately $191 million in fiscal benefits over a 15-year period.

Figure 3.3 – Effective prevention can return investment after six years[a,b]

Predicted cumulative net benefit resulting from a $100 million investment



a. The Washington State Institute for Public Policy (WSIPP) maintains a large evidence bank of a range of social programs in the US, including those targeting juvenile justice, child welfare and health care. Evidence includes comparable cost–benefit ratios, estimates of when benefits accrue over time, information about beneficiaries, and probabilities of benefits exceeding program costs. Care should be taken when drawing lessons for Australia. **b.** Expected benefits over time were modelled using Generalised Additive Models (GAMs), which were fitted to program benefit data provided by WSIPP, accounting for nonlinear relationships and varying program cost sizes.

Source: PC estimates using WSIPP data.

But the current process of funding prevention is inefficient

Governments have typically underinvested

Despite the benefits, governments tend to underinvest in prevention. It is not simple to estimate the extent of prevention expenditure across sectors. But in health care alone, the proportion of expenditure on prevention in Australia is low compared to many of our OECD peers. Australia ranked 27th out of the 36 OECD countries that reported their proportion of health spending on prevention in 2019 (figure 3.4) (OECD 2025a). In 2019, Australia allocated 2% of health spending to prevention which accounted for roughly 0.2% of GDP (OECD 2025a). Advanced economies like the UK, Canada, and Finland spent proportionally at least twice as much of their health expenditure on prevention compared to Australia.(OECD 2025a).

The Australian Government's National Preventive Health Strategy acknowledges this shortfall, and sets a target of 5% for the share of total government health expenditure going into prevention by 2030 (DoH 2021c). While this target is somewhat arbitrary, it recognises the potential value from increasing spending on preventive interventions and reflects that the scale of funding needs to be large enough to make a meaningful difference. Evidence from Canada suggests that higher public health expenditure is associated with a long-run decrease in preventable mortality and that failure to fund prevention adequately may harm populations over time (Ammi et al. 2024).

Figure 3.4 – Australia's spending on health prevention lags behind other OECD countries[a]

Pre-COVID-19 prevention as a proportion of total health spending, 2019

a. Australia's proportion of healthcare expenditure on prevention and its position relative to other OECD countries is higher in 2021 (latest year that data is available for Australia) compared to 2019. Data from 2019 is the most recent expenditure not inclusive of COVID-19 vaccination and other prevention programs.

Source: PC calculations based on OECD (2025a).

Prevention funding is not always allocated well

Even when funding is allocated to prevention, it is not always directed to programs that produce the greatest improvements in individual and societal outcomes. For example:

- drug education programs can effectively reduce the future burden of alcohol and other-drug related harms. But program effectiveness varies, and depends greatly on the developmental needs and characteristics of the target population (Alcohol and Drug Foundation May, p. 4; Newton and Lee 2019) and government investment has not consistently reflected research on program effectiveness
- there is evidence that some obesity prevention programs can produce substantial health and economic gains (Ananthapavan et al. 2020). However, obesity funding over the past ten years has been inconsistent and disaggregated, split over close to 200 programs of varying effectiveness (Tran et al. 2024).

There are a number of barriers to funding prevention

Misalignment between who benefits and who funds prevention

Government programs are often sector-specific or limited in coverage – in short, funding can be siloed – yet prevention activities can often produce benefits across different sectors and policy or program areas. The agency and level of government that funds a prevention program is not always the same as those that benefit (through future avoided costs).

Focusing on the gains from prevention to only one portfolio or level of government risks underestimating the overall benefits of prevention. Yet, most budgetary processes do not encourage agencies to collaborate on prevention initiatives to address shared problems. They instead encourage individual agencies to focus on their own organisational objectives (ANZSOG 2022, p. 5). For example:

> Our research has shown that Australia has limited policy infrastructure to connect policies across government for early childhood obesity prevention at the federal level, compared with similar countries … There is also significant overlap of responsibility for early childhood health and wellbeing between levels of government, and across care sectors. Prevention should be a shared responsibility between all levels of government and sectors but poor intersectoral governance provides opportunities for cost-shifting, where those incurring the costs do not necessarily receive the associated benefits. (Dr Vicki Brown, qr. 39, p. 2)

Budgeting rules also limit the ability for decision-makers to consider savings that accrue to other departments or agencies. For example, policy costings generally only consider the direct effects of a policy change and do not include broader, 'second-round' fiscal effects because of uncertainty around the timing and magnitude of these effects. Treasury and/or Finance could in principle consider cross-portfolio savings in decision-making, but this is rare in practice. The Charter of Budget Honesty Policy Costing Guidelines cites five examples of second-round effects being included in costs since 1994 (Commonwealth of Australia 2024, p. 7). Inquiry participants have argued that increased recognition of second-round fiscal effects would provide an incentive to invest in prevention, and an opportunity to avoid the fiscal costs of inaction (Cancer Council Australia, qr. 28, p. 7, Centre for Policy Development, qr. 96, p. 8).

Short-term thinking

Governments can be unwilling to invest in prevention because long timeframes create uncertainty – the full benefits of prevention can take years, sometimes decades to be observed. Unlike acute care, where the need is immediate and visible, preventive measures require upfront investment based on longer-term expectations. While evaluations can build confidence in specific interventions, they take time and resources.

The budget cycle puts a priority on programs with shorter-term gains. Further, budgeting rules generally do not include savings beyond the four-year forward estimate period, but many programs generate significant benefits after the four-year period. As an example, the benefits of effective prevention programs from the Washington State Institute for Public Policy database start to outweigh costs only after six years (figure 3.3).[11]

Effective prevention policy will require long-term support for initiatives that last beyond political and budget cycles.

> Programs that deliver long-term outcomes require funding models and accountability mechanisms that outlast election terms. Multi-year, outcomes-based investment - rather than short-term pilots or one-off grants - would allow providers to plan with certainty, build capability, and invest in robust evaluation. (Gotcha4Life Foundation, qr. 21, p. 5)

Limited evaluations

Inquiry participants reported that difficulties in accurately measuring and attributing the full economic and social value of prevention presented a significant barrier to funding.[12] A lack of high-quality evaluation of programs makes it challenging to properly defend the value and effectiveness of preventive interventions. Multiple reports have recognised that more high-quality, publicly available evaluations are needed (Ananthapavan et al. 2024, pp. 28–29; PC 2021, p. 29; Wise et al. 2005, p. 48). For example, PC (2021, p. 29) examined more than 200 preventive initiatives and found that only around half had published evaluations. Those evaluations tended to focus on qualitative observation of outcomes and measured

[11] Based on our analysis of prevention programs studied by the Washington State of Public Policy with a return on investment greater than 1.

[12] Dr Vicki Brown, qr.39, p. 3; GotchaLife Foundation, qr. 21, p. 3; Injury Matters, qr. 20, p. 2; Jaithri Anathapavan qr. 33, p. 2; Margo Linn Barr, qr. 35, p. 3; Medical Technology Association of Australia, qr. 47, p. 2; Playgroup Australia, qr. 22, p. 3.

outputs rather than measured outcomes – for example, the number of people treated as opposed to the number who recovered due to treatment. Causal effects of the interventions were often not established.

High-quality evaluation of preventive interventions is difficult for several reasons.

- A lack of accessible high-quality data makes it hard to measure relevant outcomes. Administrative data from different service areas and tiers of government detailing how services are used could be an alternative to primary data collection, provided it can be accessed within a useful timeframe.
- Identifying causality usually requires comparing the outcomes of comparable groups of people who do and do not receive interventions. This comparison can be difficult because of the long timeframes of preventive interventions. Many studies are observational rather than random and therefore show an association rather than causality.
- A lack of funding can mean resources are not available for high-quality evaluation (Francis and Smith 2015; Schwarzman et al. 2018), perhaps because funding bodies underestimate the resources needed or fail to include a specific allocation for evaluation (Lobo et al. 2014; Schwarzman et al. 2019).

Even in cases where rigorous evidence and evaluations exist, government agencies may lack the expertise to understand and assess the different modelling approaches that are used to study prevention. It has been suggested that:

> The epidemiological modelling required for preventive health cost-benefit analyses is different to that commonly used in other agencies, and shows that small changes to risk factors at a population level have large impacts on disease incidence. However, government departments who review these analyses … are not generally familiar with the modelling techniques. (Jaithri Ananthapavan, qr. 33, p. 2)

This means that even when there is evidence about the benefits of prevention, it is not always used to inform ongoing funding decisions.

The Australian Government has recognised the need to support policy evaluation through the establishment of the Australian Centre for Evaluation. The Australian Centre for Evaluation was set up in order to improve the volume, quality, and use of evaluation evidence across the Australian Government, working with departments to integrate high-quality evaluations into all aspects of program and policy development (ACE 2025). This is an important step in improving the evaluation capability of government agencies.

A different approach is needed

Changing the way prevention is funded is not a new idea. Previous approaches, particularly in health, have tried to support investment but inadequate consideration of the barriers to funding has held them back.

The 2009 National Partnership Agreement on Preventive Health and the Australian National Preventive Health Agency established under the agreement were seen as relatively effective (Wutzke et al. 2018). The agreement established core infrastructure for prevention programs and improved evaluation through conditional payment structures. Yet there were concerns that roles and responsibilities were not clearly defined and that there was limited collaboration from the Australian Government (ANAO 2012, p. 16,17; Wutzke et al. 2018, pp. 6–7) The agreement ended early due to claims it was duplicating other work (see the *Australian National Partnership Agreement on Preventive Health (Abolition) Bill 2014*).

The current National Preventive Health Strategy (2021–2030) has been limited by insufficient funding, the lack of a detailed implementation plan and measurable outcomes (Cancer Council qr. 28, p. 6; Each, qr. 37, pp. 4-5; Novo Nordisk (Oceania) qr. 84, pp. 2–3).

States have also taken their own approaches to supporting prevention. Independent agencies such as Preventive Health South Australia and VicHealth were established to support health prevention in their

respective states. New South Wales challenged convention by enacting 'Their Futures Matter', an evidence-based whole-of-government early intervention approach for vulnerable children and families. While the approach had ambitious goals, it was not successful as it did not establish enough independence, authority or cross-sector buy-in (NSW Auditor-General 2020, p. 2).

The Victorian Early Intervention Investment Framework is a different approach that seeks to recognise the benefits of and long-term returns from prevention by operating across sectors. The framework provides a consistent, ongoing funding process for prevention programs (box 3.2). This framework has shown early success in increasing funding for early intervention programs, though there is a lack of publicly available outcomes data or evaluations of programs.

A new nation-wide approach, that addresses barriers, is needed to overcome the structural challenges prevention funding faces across multiple sectors and levels of government.

Box 3.2 – The Victorian Early Intervention Investment Framework

The Victorian Department of Treasury and Finance introduced the Early Intervention Investment Framework in 2021-22. The framework is currently used to fund early intervention programs in education, social services, health and justice systems. Since its inception, funding has expanded from $324 million in 2021-22 (ANZSOG 2022, p. 19) to a budget commitment of $1.1 billion across 28 programs in 2024-25 (Victorian Department of Treasury and Finance 2024, p. 207). Programs funded under the Early Intervention Investment Framework through the 2024-25 budget are estimated to generate total benefits of $1–1.3 billion over the next ten years, including $655–770 million from reduced demand for government services and $360–530 million in broader economic benefits like reduced welfare payments and increased earnings (DTF 2024a).

Advantages of the framework

The framework's cross-sector approach streamlines funding proposal processes and improves inter-agency collaboration by recognising benefits across multiple portfolios and savings. Its governance structures have supported capacity for departments to complete their own applications, with the number of proposals modelled within departments increasing from 10% to nearly 50% of proposals submitted between 2021-22 and 2024-25 (DTF 2024c, p. 28). The framework considers long-term priorities, with budget proposals requiring program outcomes, costs and benefits to be calculated over ten years. To account for the risk of long-term estimation errors, the Victorian Government Department of Treasury and Finance applies a 50% discount to avoided costs when calculating departmental savings. Repayment of these savings begins in the program's third year and is completed by the tenth year.

Annual evaluation is compulsory, timely and consistent, requiring all policy proposals to quantify six outcomes and targets relevant to their initiative . The Victorian Department of Treasury and Finance uses benefit estimation modelling, evaluation and actuals to allocate funding based on policy effectiveness.

Questions around the framework remain

The robustness of the framework's cost-benefit analysis and evaluation methodology is uncertain as modelling methodology and outcomes data are not made public. Increased transparency would allow greater confidence in the framework's longer-term effectiveness. Program causality requirements could also benefit from greater stringency as programs can rely on evidence that lacks significant statistical power for public policymaking or is non-experimental (Rose et al. 2023, pp. 1-2,13).

A national framework to support government investment in prevention

The Australian Government should establish a National Prevention Investment Framework ('the framework') to support government investment in prevention programs. Its aims would be twofold: to improve outcomes for individuals, with benefits for the wider community; and to reduce demand for future acute services.[13]

The framework would support a different approach to investment by recognising that the benefits of prevention fall across sectors and levels of government, and over extended timeframes. Adoption of a robust assessment and evaluation process – discussed below – would be critical to the success of the framework. Depending on its final design, the framework could be legislated, to support its long-term sustainability.

Strong governance arrangements are required to ensure the framework provides value for money. We are proposing that an independent, cross-sectoral body be established to assess and make recommendations on program proposals. In addition, a process for funding allocation and approval is required. Options for this include a modified budgetary process and the establishment of a prevention fund. These options are discussed below.

Key to the framework is the ability for prevention to be jointly progressed by Australian, state and territory governments – this will bypass the issue of underfunding associated with different levels of government assessing the value of programs only in terms of their own fiscal costs and benefits. The comparative value of programs should consider the costs and benefits of all levels of government, with co-funding arrangements based on estimates of expected benefits. Regardless of the method of funding, agreements between the state and territory and Australian government agencies will be needed to determine roles and responsibilities of different parties.

A robust process to analyse programs

A standardised assessment process would support structured and objective evaluation of prevention programs, and consistent and transparent funding decisions. Incorporating cost-benefit and cost-effectiveness analysis in the assessment process would allow decision makers to identify programs that deliver value for money, including those that are cost-saving. It could also identify less effective programs – those that require improvement or may warrant funding withdrawal in favour of better value alternatives.

An assessment process is needed that better informs funding decisions by considering the benefits and costs of prevention across sectors and levels of government, and over longer time frames. A standardised actuarial model could draw on Australian, state and territory government administrative data to estimate these benefits and costs. Taking a rigorous approach to this will help strengthen confidence in estimates of the second-round fiscal impacts of prevention programs. Where relevant, the assessment process could include consideration of secondary factors like implementation feasibility and distributional and equity impacts (including whether the intervention provides benefits for priority populations experiencing disadvantage including, for example, Aboriginal and Torres Strait Islander people (box 3.3)).

[13] The key features of this framework are based on analysis of beneficial design features identified in Australian and international approaches to funding prevention. We analysed 12 Australian approaches, including the Victorian Early Intervention Investment Framework, NSW Their Futures Matter, NSW Investment Plan for Human Services, DSS Priority Investment Approach, and National Partnership Agreement on Preventive Health. The ten international approaches considered include NZ Social Investment Approach, British Better Care, Wales Well-being of Future Generations and Washington State Institute for Public Policy.

Box 3.3 – Prevention can improve outcomes for Aboriginal and Torres Strait Islander people

Prevention can have wide-ranging benefits and 'accelerate improvements in the lives of Aboriginal and Torres Strait Islander people' (clause 25, National Agreement on Closing the Gap). Prevention has the potential to yield a high return on investment and can deliver benefits over multiple domains. To be effective and to avoid harm, prevention needs to be sustained, culturally safe and appropriate, and designed in partnership with local Aboriginal and Torres Strait Islander people. Programs should focus on outcomes rather than activities (NACCHO, sub. 32).

> Action to improve housing conditions would see benefits for health and social outcomes, education and employment as well as mental health and wellbeing and could contribute to significant progress toward Closing the Gap targets. (NACCHO, sub. 32, p. 11)

Supporting a healthy lifestyle

Deadly Choices is a successful health promotion program that uses Aboriginal cultural identity to define healthy choices and reinforce Aboriginal people as promoters of healthy behaviour (Carson 2020). The program shares power between practitioners and community. It seeks to improve health outcomes by promoting preventive health checks, physical activity, and an end to smoking (Margo Linn Barr, qr. 35, p. 3). The school- and community-based program has increased the uptake of health checks and improved knowledge, attitudes, self-efficacy, leadership skills and behaviours, chronic disease and health risk factors (Malseed 2013, p. 6).

Supporting vulnerable youth

Justice reinvestment involves shifting resources from prisons and corrective services towards place-based and community-led preventive programs such as family support, mental health and educational services for vulnerable youth at risk of incarceration (ALRC 2017). Successful intervention can improve individual and community outcomes, while reducing future costs.

The Maranguka Justice Reinvestment Program involved a number of elements, including Aboriginal-led, service hubs and changes to justice procedures. Over one year in Bourke, police-recorded domestic violence reduced by 23%, charges across the top five juvenile offence categories reduced by 38%, days spent in custody reduced by 42%, while year 12 student retention rates increased by 31%; leading to estimated savings of $3.1 million (compared to operational costs of $0.6 million) (KPMG 2018, p. 22).[a]

There have been recent efforts to increase funding for justice reinvestment. The Australian Government has committed $69 million over four years from 2022-23, and $20 million a year from 2026-27, for a National Justice Reinvestment program to support 30 community-led initiatives (AGD 2025).

a. The impact assessment did not establish a causal link, and there is a need to build further evidence.

In practice, the framework could support prevention activities across a range of portfolios that meet the criteria for cost-effectiveness and net benefits. It could support programs at any stage of prevention shown in figure 3.1, across a range of age cohorts and that realise benefits over different time periods. It could support smaller, local and scalable interventions but also more significant investment into larger programs. It could also ensure a focus on existing areas that the government has made a priority, including in the National Agreement on Closing the Gap and Working for Women: A Strategy for Gender Equality, or on the priority cohorts identified in the National Preventive Health Strategy 2021-2030 (DoH 2021c).

One approach could be that investment is diversified to ensure that funding goes to programs across different sectors and with both short-term and long-term impacts. This approach may help balance the higher risk but potentially larger returns of many long-term prevention programs with more certain, quicker gains of shorter-term programs. The extent to which a diversification strategy is possible may depend on the specific funding mechanism chosen to support the framework.

Funding timeframes should be long enough to ensure that programs' benefits are realised. But to have confidence in this, rigorous and regular evaluations will be required. A portion of program funding will need to be allocated for evaluations to ensure that they are sufficiently resourced.

A pragmatic approach to evaluation

A one-size-fits-all approach to evaluating programs is neither possible nor appropriate. Factors such as the degree of targeting in a program, challenges in estimating causal effect, the length of time before anticipated benefits are realised and the scale of the intervention, will all affect evaluation.

Different methods of evaluation will be necessary in different circumstances. Randomised trials are often considered the gold standard for establishing a program's causal effect on outcomes, but they are not always feasible. Developing guidelines around the appropriate use of different methods will be important for ensuring that funding remains available for populations and policy challenges where randomised evidence is hard to collect but the need for prevention remains high.[14]

Requirements could also be relaxed for smaller investments or alternative standards of evidence could be developed for smaller program proposals, with evaluation requirements tailored to the size, significance and risk of initiatives (NSW Treasury 2023, p. 23). Ananthapavan et al. (2021, p. 11) has suggested that cost-benefit analysis should only be used for government investments greater than $10 million in total.

Further, programs with long-term benefits may need different evidence requirements and outcome reporting standards. In these cases, reporting on lead and lag indicators could provide early information on long-term outcomes. Lead indicators are measurable factors that focus on the processes that influence future outcomes, whereas lag indicators provide less specific service information and can be harder to change in the short term (Molloy et al. 2025, p. 791). For example, a lead indicator in antenatal care is the percentage of pregnant women who attend a booking appointment within the first trimester, while a lag indicator is the infant mortality rate. There will be a trade-off between the requirement to continually evaluate programs and the need to limit administrative burden and maintain longer-term and consistent funding, particularly for initiatives that may yield outcomes over a longer timeframe.

[14] See Rose and Mildon (2022) for a summary of different methodological designs to evaluate outcomes of early interventions.

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?

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

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?

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

Implementing a prevention framework across government

The successful implementation of a prevention framework that takes a long-term, whole-of-government perspective requires:

- a Prevention Framework Advisory Board to help build the evidence base for interventions and prioritise interventions to recommend for funding across different sectors
- a mechanism to allow for ongoing Australian Government funding of prevention
- supporting agreements that establish the framework's roles, objectives and processes for the Australian, state and territory governments.

These changes would bring rigour to the consideration of prevention programs and should also drive a change in how prevention is viewed in government, recognising that prevention is a fiscally responsible and sustainable approach, and a key means of improving people's lives and reducing fiscal pressures over the medium to long-term.

Prevention Framework Advisory Board

A cross-sectoral Prevention Framework Advisory Board (PFAB)[15] should be established to assess and provide advice on funding proposals based on the agreed assessment process. To receive funding under the framework, recommendation by the PFAB would be required, with this assessment to be released publicly. PFAB should set ongoing reporting requirements, build the evidence base and provide guidance on priorities for prevention funding. It should receive ongoing federal funding to perform its functions.

Some have suggested that other agencies like the Australian Centre for Disease Control could play a role in assessing preventive health interventions, similar to what we are recommending for the PFAB. However, we recommend a broader PFAB because effective preventive interventions exist across a range of spending areas – not just health.

Some functions of PFAB could be modelled on aspects of the Pharmaceutical Benefits Advisory Committee (PBAC) and the Medical Services Advisory Committee (MSAC) (box 3.4). Its membership should include experts from prevention-related sectors (for example, health care, social services, justice and education),

[15] PFAB is based on work done by Harris and Mortimer (2009) but has a broader, cross-sectoral focus that allows for consideration of programs and outcomes including and beyond the health sector.

including those with expertise in economics who can advise on cost-benefit analysis and evaluation. PFAB membership and processes should support shared decision-making with Aboriginal and Torres Strait Islander people by establishing strong and representative partnerships, underpinned by accountability mechanisms (PC 2024e, p. 39). PFAB should help agencies from different jurisdictions to analyse and develop proposals.

PFAB should meet regularly to review applications and make recommendations for funding, and it could set deadlines for proposals accordingly. PFAB should also set timelines for the ongoing review and approval of interventions and recommend whether programs should be considered for ongoing funding, scaling up, scaling down or defunding. It could conduct initial application pre-assessments to confirm suitability and target population.

Box 3.4 – Medical Services Advisory Committee and Pharmaceutical Benefits Advisory Committee

The Medical Services Advisory Committee (MSAC) and Pharmaceutical Benefits Advisory Committee (PBAC) conduct assessments in Australia to ensure that spending within the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme is directed to clinically and economically effective health services and medicines decisions (DHDA 2016, 2024). The committees' governance, funding and evaluation processes support them to produce robust assessments that directly inform funding.

Structure and governance

- **Type of committee**: MSAC is an independent, non-statutory body while PBAC is a statutory body.
- **Committee composition**: MSAC members include experts in clinical medicine, health economics and consumer matters. To develop assessment reports, MSAC also takes advice from approved health technology assessment groups such as universities or professional bodies. PBAC includes additional health professionals, consumer representatives and an industry-nominated member.

Funding

PBAC uses a cost-recovery framework with companies that submit proposals partially covering process costs (Kim et al. 2021, p. 2). MSAC is currently funded through the Department of Health, Disability and Ageing's budget allocation, although the Australian Government has agreed to implement a cost-recovery framework (DoHAC 2022).

Submissions process

The process and collaboration guidelines support good healthcare outcomes by producing comparable and reliable evaluations that support the funding of cost-effective services and medicines with strong evidence of health benefits.

- **Efficiency**: The MSAC process begins with pre-assessment to confirm an application's suitability and its target population, avoiding consideration of impractical proposals. PBAC distinguishes between submission category, allowing some submissions to undertake a streamlined process.
- **Final decision maker**: All Pharmaceutical Benefits Scheme listings require both PBAC endorsement and Ministerial approval. The Health Minister makes the final decisions after relevant government agencies and the Department of Finance have approved the recommendation, including an estimate of financial impact. If the listing has a significant financial cost (more than $20 million in each of the forward estimate years) then Cabinet must consider it.
- **Transparency**: Both MSAC and PBAC publish outcome summaries to promote transparency, though MSAC provides less detailed information.

Data and evaluation

As part of its functions, PFAB could develop standard cost-benefit and cost effectiveness analysis frameworks (or adopt existing ones) and an in-house actuarial model to guide standardised analysis of proposals and programs. This model, by drawing on Australian Government and state services data (such as from the Australian Bureau of Statistics' Person-Level Integrated Data Asset, and the Australian Institute of Health and Welfare's National Health Data Hub), could be used to estimate the potential benefits of targeted interventions (box 3.5). Access to Australian Government funding could be made conditional on states contributing necessary data under the terms of the Agreement, noting that some states and territories already have initiatives underway to integrate data.

The model could be made available to all participating jurisdictions to support consistent and systematic modelling of benefits and costs, identification of priority cohorts and development of policy proposals.

Box 3.5 – Identifying priority cohorts using estimates of lifetime service use

Actuarial models, like NSW's Forecasting Future Outcomes Report (Taylor Fry 2018) and the Department of Social Services' Priority Investment Approach (AGA 2022), use linked administrative data to predict how much individuals are likely to use a service in the future.

Estimation process

Linked administrative data provides information on an individual's use of services across agencies. The NSW approach created a summary of service use and outcomes for individuals in the data set every year from birth to 2016-17. Based on individual summaries, the model predicted outcomes and service use for participants until age 40. It also incorporated data on predictable service use pathways: for example, someone entering corrections is more likely to continue to interact with the justice sector. Individual predictions were aggregated to provide cohort- and population-level insights.

Usefulness of approach

Actuarial approaches can reveal cohorts that are expected to require significant future government assistance. NSW defined six priority cohorts (for example, vulnerable children aged 0-5) that account for a disproportionate share of service delivery costs and often experience worse social outcomes. For example, 50% of estimated future costs were associated with 7% of the study population (Taylor Fry 2018, p. 47). Targeting these cohorts can have significant impacts. For example, a youth justice intervention in NSW may have more impact if it targets 'vulnerable young people transitioning to adulthood', since individuals in this priority cohort are eight times more likely than a matched population control group to enter custody. As well as informing priority cohorts, long-term cost estimates can build the evidence base for new prevention policies and support the monitoring and evaluation of policies.

Increasing investment in prevention

Governments are under constant financial pressure, and securing new funding for prevention may be a challenge. But governments should remain mindful of the high value of prevention investment – both in terms of future avoided costs and improved outcomes for the community. Investment in prevention has potential to improve budget sustainability by bringing forward some future spending, making overall expenditure lower

than would otherwise be the case while delivering better outcomes for the community. While governments could consider reallocating funding from existing budget items, especially those that are ineffective, overlap or duplicate other programs, new investment for prevention will be required if governments want to improve outcomes and limit growth in future care expenditure.

Existing and previous funding arrangements and strategies provide a useful rule of thumb for the amount of government investment in prevention.

The National Preventive Health Strategy recommends allocating 5% of all healthcare expenditure to prevention by 2030 and there is widespread support for alignment with the strategy's targets.[16] This would equate to about $8.9 billion in prevention funding for health care alone, in 2022-23 (AIHW 2024b). Additional funds would be required with consideration of the whole care sector.

A different benchmark 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). Scaled nationally based on population, this figure would amount to about $3.3 billion.[17]

The previous National Partnership Agreement on Preventive Health stated the maximum annual amount of funding that the Australian Government could provide states and territories, starting with up to $2.5 million for prevention programs in 2009-10. The total scheduled funding increased every year, reaching a maximum of $236 million in 2014-15 ($51.5 million in facilitation payments and $184.5 million reward payments for targets being met) (COAG 2008, p. 10). But the agreement was health-focused and narrow in scope compared with the cross-sectoral national framework proposed in this paper. Moreover, care expenditure needs have increased in the decade since the agreement was struck.

The contributions of the Australian, state and territory governments will depend on the expected benefits of programs chosen for funding, their potential returns and the timeframes over which funding is provided.

Possible funding mechanisms

Well-designed funding mechanisms can help overcome existing barriers to funding prevention, such as governmental siloes and a focus on short-term outcomes. To do so, these mechanisms should:

- allow for co-funding, with state and territory governments to make contributions to programs based on their expected benefits. This ensures the cross-jurisdictional benefits of a program are considered, and programs that might not otherwise be funded will receive support
- consider the expected outcomes associated with programs, including the potential effects across sectors and levels of government, and over longer-time frames. Eligibility for funding should be assessed by taking a broad perspective in evaluating costs and benefits to different areas and levels of government
- facilitate ongoing funding for successful prevention programs to avoid 'funding cliffs' associated with grant-based funding.

A modified budget process for prevention programs

One approach is for individual preventive programs to be considered through the Australian Government budget process following a recommendation from PFAB, with some modifications. Under the framework,

[16] Cancer Council Australia, qr. 28, p. 2; Catholic Health Australia, qr. 65, p. 12; Deafness Forum Australia, qr. 34, p. 5; Deakin University's Faculty of Health; Institute for Physical Activity and Nutrition (IPAN); Institute for Health Transformation (IHT); SEED Centre for Lifespan Research, qr. 69, p. 3; Dr Vicki Brown, qr. 39, p. 7; Each, qr. 37, p. 4.
[17] Assuming that Victoria is about a quarter of the Australian population (ABS 2025b).

agencies could work with the PFAB to build evidence-based program proposals. PFAB would provide modelling support and advise on the second-round fiscal effects and long-term benefits of proposed preventive activities. Relevant ministers would then bring forward policy proposals for consideration by Expenditure Review Committee and Cabinet.

This would embed consideration of prevention activities in the budget process and enable the ongoing consideration of programs. However, there is risk that prevention activities would encounter the same barriers to funding as they do currently, with more immediate spending pressures being given priority.

This risk could potentially be mitigated with several adjustments.

- The Budget Process Operational Rules could be adjusted to allow for second-round fiscal effects in policy costings relating to preventive programs (Gaukroger and Phillips 2024).
- The Expenditure Review Committee could hold specific prevention meetings to consider submissions that had been assessed previously by the PFAB.
- There could be enhanced public reporting on prevention investments (for example a statement on preventive investments that improve care productivity in budget papers and/or the fiscal costs of preventive inaction included in the Intergenerational Report).

A National Prevention Investment Fund

An alternative would be to quarantine funding for prevention in a National Prevention Investment Fund, similar to the National Productivity Fund and Health Innovation Fund. The fund would involve a multi-year commitment (such as 5–10 years) from the Australian Government to prevention, from which funding could be allocated based on specific program proposals. State and territory governments and Australian Government departments would propose programs that draw on these funds. Payments from the fund would depend on a recommendation from the PFAB and the Minister responsible for the National Prevention Investment Fund and approval to release funds would pass through Expenditure Review Committee and Cabinet via the budget process.

This approach has the benefit of ensuring that funds are quarantined for preventive purposes and allow for longer-term funding beyond the forward estimates.

Enabling joint efforts between the Australian, state and territory governments

Collaboration with the state and territory governments and assessing costs and benefits over both levels of governments is a key element of the framework and will mean that some programs that would not otherwise be funded could receive the support needed for implementation. State and territory governments would be expected to co-fund programs that are proposed, based on their share of expected benefits.

As a result, and regardless of the method of funding, agreements between the Australian, state and territory governments may be required.

For example, the framework may require an intergovernmental agreement between the Australian, state and territory governments which would set out commitments to co-funding prevention programs. It would outline the roles and responsibilities of the Australian, state and territory governments and the PFAB. Federation funding agreement schedules will also be required to facilitate payments from the Australian Government to states and territories. These schedules could play a key role in determining the obligations of the parties, such as co-contributions and ongoing reporting and evaluation requirements (as set by the PFAB). They could include a formula that calculates the expected co-contributions of state and territory governments based on the net future benefits expected to accrue to them, ensuring that the funding burden is shared

proportionately and incentives are sufficiently aligned. The agreement should also make clear that state and territory governments must maintain funding for existing effective programs.

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?

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

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

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?

Appendix

A. Public consultation

This appendix outlines the consultation process and lists the organisations and individuals who participated in the inquiry. The PC received the terms of reference for this inquiry on 13 December 2024. The PC consulted with 63 individual organisations (table A.1). A consultation questionnaire was released on 19 May 2025 seeking feedback on specific aspects of our policy reform areas. In total, 96 responses to the questionnaire (table A.2) were received. An additional 33 submissions were received via email (table A.3). The questionnaire responses and submissions are available at: engage.pc.gov.au/projects/quality-care/page/pillar-4-responses.

The PC would like to thank everyone who has participated in this inquiry.

Table A.1 – Consultations

Participants
Aged Care Quality and Safety Commission
Ageing Australia
Associate Professor Ben Spies-Butcher (Macquarie University)
Associate Professor Gareth Bryant (University of Sydney)
AusActive
Australian Council of Social Services (ACOSS)
Australian Council of Trade Unions (ACTU)
Australian Government Department of Education
Australian Government Department of Finance
Australian Government Department of Health, Disability and Ageing
Australian Government Department of Social Services (DSS)
Australian Government Department of the Prime Minister and Cabinet (PM&C)
Australian Government Department of Veterans Affairs (DVA)
Australian Government Treasury
Australian Healthcare & Hospitals Association (AHHA)
Australian Human Rights Commission (AHRC)
Australian Institute of Health and Welfare (AIHW)
Better Health Network (BHN)
Boston Consulting Group (BCG)
Burnet Institute

Participants

Business Council of Australia (BCA)
Central and Eastern Sydney Primary Health Network (CESPHN)
Centre for Policy Development (CPD)
Coalition of Aboriginal and Torres Strait Islander Peak Organisations (the Coalition of Peaks)
Disability Advocacy Network Australia (DANA)
Dr. David Cullen
Eastern Melbourne Primary Health Network (EMPHN)
Gippsland Primary Health Network
Grattan Institute
Health Services Union (HSU)
Holstep Health
HumanAbility
Independent Health and Aged Care Pricing Authority (IHACPA)
Medical Software Industry Association (MSIA)
Murray Primary Health Network
Murrumbidgee Local Health District (NSW Health)
National Aboriginal Community Controlled Health Organisation (NACCHO)
National Disability Services (NDS)
NDIS Quality and Safeguards Commission
New Zealand Social Investment Agency
North Western Melbourne Primary Health Network (NWMPHN)
Northern Sydney Local Health District (NSW Health)
NSW Health
Primary Health Tasmania
Professor Bruce Bonyhady
Professor Mark Considine
Public Health Association of Australia (PHAA)
Queensland Health
Ralph Lattimore
Rebbeck
SEED Futures
Social Ventures Australia (SVA)
South Eastern Melbourne Primary Health Network (SEMPHN)
South Western Sydney Primary Health Network (SWSPHN)
Sydney North Health Network

Participants
The Front Project
The Safer Air Project
VicHealth
Victorian Aboriginal Community Controlled Health Organisation (VACCHO)
Victorian Department of Treasury and Finance
WA Primary Health Alliance
Western Sydney Primary Health Network (WentWest)
Western Victoria Primary Health Network

Table A.2 – Questionnaire responses

Participants	qr no.
Advanced Pharmacy Australia	60
Anita Franklin	4
Australian Health Promotion Association (AHPA)	76
Australian Industry Group (Ai Group)	50
Belinda	7
Bronwen Mary Dalton	19
Business Council of Co-operatives and Mutuals (BCCM)	52
Cancer Council Australia	28
Care Economy CRC	51
Carers NSW	78
Caroline Robinson	75
Catholic Health Australia (CHA)	65
Centre for Community Child Health (CCCH), Murdoch Children's Research Institute	93
Centre for Policy Development (CPD)	96
Co-Chairs Prof. Alta Schutte and Prof. Markus Schlaich, on behalf of the National Hypertension Taskforce	42
Community Council for Australia (CCA)	32
Deafness Forum Australia	34
Deakin University's Faculty of Health; Institute for Physical Activity and Nutrition (IPAN); Institute for Health Transformation (IHT); SEED Centre for Lifespan Research	69
Dental Health Services Victoria (DHSV)	38
Diabetes Australia	45
Dr Stephen Alomes	59
Dr Vicki Brown	39
Each	37

Participants	qr no.
Fixing the NDIS research team, Centre for Disability Research and Policy, The University of Sydney	31
Flinders University	87
Gotcha4Life Foundation	21
Grattan Institute	56
GSK Australia	66
Harbison Residential Care Limited t/as Harbison	43
Health Consumers' Council WA	48
Injury Matters	20
International Centre for Future Health Systems & Centre for Social Research in Health UNSW	23
Jaithri Ananthapavan	33
Julie Thorpe	40
Kaarin Jane Anstey	94
Lauren Hutton	5
Liz Keen	13
Margo Linn Barr	35
Medical Software Industry Association (MSIA)	77
Medical Technology Association of Australia (MTAA)	47, 63
Medicines Australia	81
Minda Incorporated	8
Mission Australia	62
Montu Group Pty Ltd	84
Mudgee Region Health Alliance	83
Municipal Association of Victoria (MAV)	44
Murrumbidgee Primary Health Network (MPHN)	89
National Centre of Excellence in Intellectual Disability Health (NCEIDH)	80
National Disability Services (NDS)	85
National Eating Disorders Collaboration (NEDC)	54
Novo Nordisk (Oceania)	55
Pfizer Australia	71
Playgroup Australia	22
Rebecca Cannon	30
Rehabilitation Medicine Society of Australia and New Zealand (RMSANZ)	82
Royal Australasian College of Physicians (RACP)	64
Scleroderma Australia	67
Scope (Aust) Ltd	27

Participants	qr no.
Stella Perkins	16
Susan Mendez	36
Sydney Policy Lab at the University of Sydney	61
The Australian Prevention Partnership Centre	86
The Benevolent Society	73
The George Institute	68
The George Institute for Global Health and The Leeder Centre for Health Policy, Economics and Data	72
The Health Alliance, a joint initiative of Metro North Health and Brisbane North PHN	70
The National Rural Health Alliance	97
The Retirement Living Council (RLC)	98
The Safer Air Project	57
The Salvation Army Australia	24
The Tech Council of Australia (TCA)	88
United Way Australia	58
Uniting Church in Australia Queensland Synod	26
UnitingCare Australia	95
UnitingNSW.ACT	53
Vicki Winfield	14
Victorian Department of Health	46
Wellbeing and Prevention Coalition in Mental Health	74
Wes Morris	91
Working with Women Alliance (WwWA), Australian Multicultural Women's Alliance (AMWA)	92
Anonymous	1
Anonymous	2
Anonymous	3
Anonymous	6
Anonymous	9
Anonymous	10
Anonymous	11
Anonymous	12
Anonymous	15
Anonymous	17
Anonymous	25
Anonymous	29
Anonymous	41
Anonymous	79
Anonymous	90

Table A.3 – Submissions

Participants	Sub no.
Ageing Australia	20
AIRAH	31
Australian Academy of Science (AAS)	27
Australian Commission on Safety and Quality in Health Care (ACSQHC)	29
Australian Council of Social Service (ACOSS)	14
Australian Council of Trade Unions (ACTU)	23
Australian Dairy Products Federation (ADPF)	17
Australian Healthcare and Hospitals Association (AHHA)	26
Australian Institute of Company Directors (AICD)	8
Australian Services Union (ASU)	6
Bupa Asia Pacific	10
Business Council of Australia (BCA)	7
Centre for Future Work at the Australia Institute	12
Centre for Policy Development	33
Chamber of Commerce and Industry Western Australia (CCIWA)	13
Commonwealth Bank of Australia (CBA)	24
Community Flower Studio	1
Council of Small Business Organisations Australia (COSBOA)	22
Dementia Australia	2
Group of Eight	30
HumanAbility	3
KPMG	25
Lite n Easy	4
Massage & Myotherapy Australia	11
National Aboriginal Community Controlled Health Organisation (NACCHO)	32
NewDirection Care	9
Private Healthcare Australia (PHA)	18
Public Health Association of Australia (PHAA)	16
Regional Australia Institute (RAI)	5
Royal Australian College of General Practitioners (RACGP)	28
Silverchain	15
The Pharmacy Guild of Australia	21
VicHealth	19

Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
ACDC	Australian Centre for Disease Control
AI	Artificial intelligence
AIHW	Australian Institute of Health and Welfare
BiOC	Birthing in Our Communities
COVID-19	Coronavirus disease of 2019
DTF	The Victorian Department of Treasury and Finance
ECEC	Early childhood education and care
EIIF	Early Intervention Investment Framework
ERC	Expenditure Review Committee (of Cabinet)
GDP	Gross Domestic Product
HHS	Hospital and Health Service
IQ	Intelligence quotient
IUIH	Institute for Urban Indigenous Health
LHN	Local hospital network
MSAC	Medical Services Advisory Committee
NDIS	National Disability Insurance Scheme
OECD	Organisation for Economic Co-operation and Development
PBAC	Pharmaceutical Benefits Advisory Committee
PBS	Pharmaceutical Benefits Scheme
PC	Productivity Commission
PFAB	Prevention Framework Advisory Board
PHN	Primary health network
PLIDA	Person-Level Integrated Data Asset
QCP	Queensland-Commonwealth Partnership
QR	Questionnaire response
UK	United Kingdom
US	The United States of America
WSIPP	Washington State Institute for Public Policy

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