Australian Government
Productivity Commission

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Delivering quality care more efficiently

What we heard

Inquiry paper

December 2025

Acknowledgement of Country

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.

About us

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

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Introduction

In December 2024, the Australian Government tasked the Productivity Commission with undertaking five inquiries aimed at identifying priority reforms and developing practical, implementable recommendations to boost Australia's productivity growth.

As part of the terms of reference, the PC was asked to engage widely and consult appropriately, including by inviting public submissions.

For this inquiry into *Delivering quality care more efficiently*, we sought to understand people's experiences of both giving and receiving care, identify key barriers to greater efficiency while recognising the need for care to be of a high quality and gather practical suggestions for improvement.

We focused on three priority reform areas:

- reforming quality and safety regulation to support a more cohesive care economy
- embedding collaborative commissioning to increase integration of care services
- developing a national framework to support government investment in prevention.

This what we heard paper summarises the perspectives of participants who engaged with the inquiry through an online questionnaire and written submissions – a summary of key statistics from the consultation process on the inquiry is provided in figure 1. It seeks to reflect the written feedback received, organised by key themes across the reform areas explored in the inquiry.

All questionnaire responses and submissions were read and considered by staff and coded using NVivo software, a qualitative analysis software.

We thank participants and acknowledge the valuable contributions to this inquiry from care users, carers, workers, peak bodies, Aboriginal Community Controlled Organisations, unions, professional associations, care providers, researchers and government agencies.

Figure 1 – Participation in consultation process

Questionnaire responses

96 Total questionnaire responses received

Responses received for each reform area

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

44 Embed collaborative commissioning to increase the integration of care services

72 A national framework to support government investment in prevention

Respondent type (%)

45	Industry or advocacy organisation, professional association or peak body
22	Organisation that provides or coordinates care
10	Academics/researchers
7	Interested community member
6	Care user
4	Other provider of care
3	Government
2	Care worker

Submissions

257 Total submissions received

33 Pre-interim report submissions

224 Post-interim report submissions

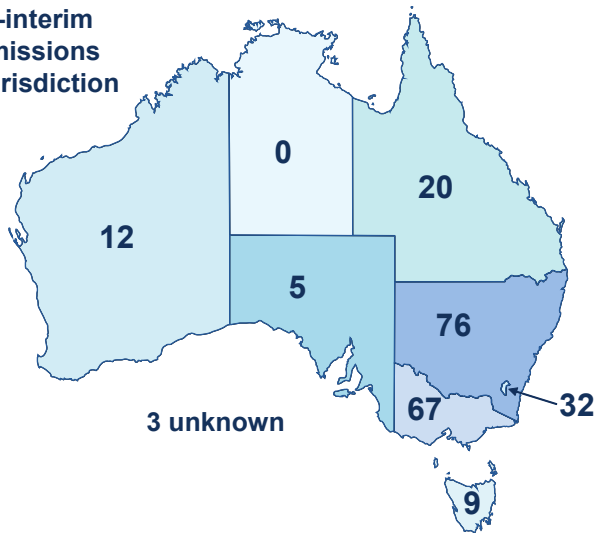
Post-interim submissions from

194 Organisations

30 Individuals

5 Aboriginal and Torres Strait Islander individuals/organisations

Post-interim submissions by jurisdiction



Other consultations

111 Meetings

3 Roundtables

The true value of consultation and engagement lies in the insights that are shared by participants. Their input highlights the importance of ensuring people are at the centre of policy reform in the care economy. The following reflection from a participant illustrates a perspective (box 1):

Box 1 – The Road We Walk (A citizen's reflection for Pillar 4: Delivering Quality Care More Efficiently)

Most of life is lived in ease. We walk the road without thinking about it, moving through the ordinary hours. Yet when crisis comes — sickness, frailty, loss — the road vanishes. The familiar path is swallowed by fog, and time itself seems to stumble.

In those moments, care is everything. A hand to steady us, a signpost to guide us, a lantern to make the path visible again. Some are lucky enough to have family who step forward. But not all families are able, and not all are present. Then the village must expand — care must be civic as well as private, shared as well as personal.

To deliver care efficiently is not to ration it, nor to count minutes like coins. It is to recognise that time in crisis is not ordinary time. A day in a hospital bed is not the same as a day at work; an hour waiting for help in pain stretches longer than a week of health. Efficiency means meeting people where they are in those altered hours, and restoring them to the everyday time of living.

The road of life is long, and its crises rare. Yet precisely because they are rare, when they come we need to feel supported, not abandoned. Systems of care should be designed like waystations along the road: dependable, humane, present when called upon. Not cluttered with broken lanterns, not scattered with confusing signs, but clear and steady.

Care is not wasted time. It is what allows life to continue. To measure its efficiency is not to shrink it, but to ask: how well do we help people back onto the road? How well do we use society's time to ease those moments when time seems unbearable?

Source: Anonymous, sub. 49, p. 1.

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

Regulation is an essential part of the care economy, making workers and providers accountable, reducing harm, driving improvement in outcomes, and setting minimum standards to ensure that care users are treated with dignity, fairness and respect. In our consultations, we sought to understand the overlap of regulation, the burden of duplication and potential opportunities for aligning quality and safety regulation across care sectors. We identified four key themes from the questionnaire responses and submissions.

Complex and fragmented regulation
Examples of duplicative and fragmented regulations and their effects on care users, providers and workers

Alignment considerations
A range of considerations for aligning regulation are outlined and sector differences noted

Principles to underpin alignment of regulation
Key principles that should underpin any alignment of regulation

Implementation
Key factors that may affect implementation of reforms

Complex and fragmented regulation

Participants noted the challenges that complex and fragmented regulation creates when operating across care sectors, adversely affecting some providers, for example smaller providers or those operating in regional areas, more than others.

> The current regulatory environment for care providers is fragmented and administratively burdensome. Providers operating across aged care, disability, and veterans' care services are often subject to multiple, overlapping standards and audit regimes, which creates duplication, confusion, and compliance fatigue. This is particularly challenging for smaller and regional providers, who may lack the resources to manage complex and inconsistent requirements. (National Disability Service (NDS), sub. 241, p. 13)

> Small businesses generally have less capacity to manage regulatory complexity, and this is compounded by lack of legislative and regulation harmonisation across the various levels of government and systems under it. (Australian Small Business and Family Enterprise Ombudsman, sub. 231, p. 8)

> Fragmented, duplicative regulatory requirements are one of the greatest drags on productivity in the care economy. For small states like Tasmania, these burdens are amplified, discouraging providers and overwhelming frontline workers. (St Luke's Medical and Hospital Benefits Association, sub. 238, p. 1)

> due to the poor alignment of regulatory systems between disability, aged care and primary healthcare, many ACCHOs are overburdened with maintaining regulatory requirements. The burden of reporting and compliance across multiple systems is significant and the additional

> staffing needed to manage separate processes is generally not funded. (National Aboriginal Community Controlled Health Organisation (NACCHO), sub. 215, pp. 15–16)

Participants shared how this complex, inconsistent and fragmented regulation affected care users, providers and workers in a myriad of ways.

> 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)

> In practice, services are insufficiently resourced to meet the administrative requirements to demonstrate the maintenance of these standards through disparate processes, with the diversion of resources from service delivery to compliance activities, an efficiency risk. [Mental Health Victoria] member organisation, Better Health Network, report costs of approximately $200,000 annually to meet regulatory obligations. (Mental Health Victoria, sub. 253, p. 5)

> Staff working nationally may be required to hold up to seven separate checks — one for each jurisdiction — despite the underlying purpose and assessment criteria being nearly identical. This contrasts with NDIS accreditation where there is a nationally recognised single assessment process. (The Benevolent Society, qr. 73, p. 4)

Alignment considerations

Many submissions supported regulatory alignment across aged care, NDIS and veterans' care, noting potential benefits for efficiency and improved outcomes. While many gave in principle support for draft recommendation 1.1 – the Australian Government pursue greater alignment in quality and safety regulation of the care economy to improve efficiency and outcomes for care users – they stressed the need for careful consideration of how each alignment action could be implemented in practice.

> Overall, the Commission gives in principle support for the intent of draft Recommendation 1[.1] but suggests the report would benefit from a detailed consideration of the practicalities of implementing the recommendation. While there are key areas where alignment is both beneficial and appropriate, there are also areas in which reasonable adjustments to any aligned model may be necessary to account for varying contexts, risks and care users across care sectors. It is important that these differences are explored in finalising the recommendations to ensure regulation continues to align with best practice principles, including an ability to respond to and prevent harm, and being proportionate and risk-led. (Aged Care Quality and Safety Commission, sub. 256, p. 3)

> Regulatory alignment can be achieved in a way that does not limit the ability for consumers to access services that meet their individual needs. Striving for regulatory alignment must not lead to services being 'standardised', nor should it limit the choice and control of NDIS participants over their services. The needs of people with disability, older people, and veterans are diverse. Individual differences need to be accommodated even when people are accessing the same type of service, or even from the same provider. (NDIS Quality and Safeguards Commission, sub. 258, p. 7)

Participants stressed that any alignment must not weaken quality and safety.

> KU supports aligning regulatory frameworks to reduce duplication and improve workforce mobility, provided harmonisation does not compromise existing standards. Rather, it should promote consistency and uphold standards for quality and safety. (KU Children's Services, sub. 196, p. 4)

> Under no circumstances should "efficiency" measures dilute the quality, safeguards or person-centred focus of disability services. (JFA Purple Orange, sub. 237, p. 12)

Some participants went further and questioned whether alignment was appropriate at all.

> It is generally our view that the attitude that the care sectors are substantially the same and that they are largely interchangeable is fundamentally incorrect and is largely held by those outside the sector with little specific knowledge of the different care contexts, operating environments and needs of the recipients of care in the individual sectors. (Australian Council of Trade Unions, sub. 23, p. 12)

While others proposed that alignment could and should adequately account for differences between sectors.

> It is essential to recognise and incorporate the unique nuances in care that vary based on individual needs, the group receiving the care, the specific settings in which care is provided, and the associated risks. (Silverchain Group, sub. 204, p. 2)

> Any alignment must preserve flexibility for context-specific differences, recognising the unique needs of older Australians, people with disability, and veterans. (Anglicare Sydney, sub. 138, p. 4)

Detailed feedback on each alignment action, along with specific considerations, is presented in the following sections.

Worker screening and registration

There was broad support for simplifying and aligning worker regulation, as proposed in draft recommendation 1.1, particularly through a national worker screening clearance.

> NDS strongly supports the development of a single, nationally recognised screening clearance for workers across all care sectors. This reform has the potential to reduce duplication, accelerate recruitment, and ensure consistent safety standards. (NDS, sub. 241, p. 20)

Participants identified a range of benefits from aligning worker regulation and shared views on how aligned screening and registration could work. These are outlined below.

Support for national worker screening to improve mobility and safeguards

> "A unified approach to worker screening would assist with mobilising the workforce and providing greater flexibility and alignment in the care sector. (Queenslanders With Disability Network, sub. 149, p. 4)"

> "A unified, portable clearance system and shared professional standards for core roles (e.g., care coordinators, support workers) would simplify recruitment and increase workforce mobility. (Flinders University, qr. 87, p. 2)"

Support for worker registration to strengthen accountability

> "Registration, supported by professional standards and clear codes of conduct, strengthens accountability and provides assurance of competence beyond risk-based screening alone. Investment in a quality registration system that incorporates practice standards, rather than relying solely on criminal history checks or worker clearances, delivers stronger safeguards and improves the safety, professionalism and responsiveness of the workforce. (Victorian Disability Worker Commission, sub. 175, p. 2)"

Design considerations for worker screening

> "The implementation of such a national worker screening scheme in aged care, NDIS and veteran's care should also consider issues faced by Indigenous workers, whose experience of screening can involve lengthy delays due to difficulties in locating identity documents (e.g., birth certificates). (United Workers Union (UWU), sub. 199, p. 27)"

> "While a single, streamlined check would help reduce these inefficiencies, it is essential that the clearance process maintains a sufficiently robust standard to ensure community confidence and trust in the care workforce. (Australian Nursing and Midwifery Federation, sub. 87 , p. 6)"

Design considerations for worker registration

> "Significant work will be required to create a registration system with sufficient nuance and flexibility to accommodate this. Otherwise, the system will create confusion and mismatch and will hinder, rather than support, the delivery of person-centred, human rights-based care. We support the proposed concept of a system that can "accommodate different skills, qualifications or experience requirements" without tying registration classes to a particular sector, as this would allow for further development and recognition of specialisations and specific skillsets required for care in different contexts. (Australian Association of Gerontology, sub. 134, p. 6)"

Provider suitability tests, registration and audits

Submissions highlighted the potential benefits of more consistent approaches to provider regulation.

> A unified registration process has the potential to encourage market expansion, support new entrants (including small and community-based providers), and stimulate innovation by allowing providers to differentiate themselves on value, quality, and care models. (KPMG Australia, sub. 115, p. 2)

But many reiterated that any alignment in the use of common suitability tests and mutual recognition of audits should account for differences between sectors and not weaken standards.

> While we do not oppose a common suitability test, the testing process must recognise the unique needs of participants in the service systems. For example, it would be inappropriate for a provider with experience in aged care to be deemed suitable to provide support to younger people with intellectual disabilities and complex needs without any experience in providing that support or without any knowledge of evidence-based practice to improve the quality of life of the person with disability. (Australasian Society for Intellectual Disability, sub. 58, p. 2)

> Any mutual recognition must ensure that services are held to existing or higher standards and avoid allowing providers to be audited against less stringent requirements. (Uniting NSW.ACT, sub. 114, p. 3)

Participants gave qualified support for a single digital portal, highlighting the need for adequate resourcing and funding to undertake such a significant project.

> The Commission's proposal to implement a single digital portal for provider registration and audits would streamline compliance and free up resources for frontline care. This must be supported with sufficient resources to ensure that providers are not subjected to the administrative backlogs often experienced in large governmental departments. Critical to the design of such a portal is transparency regarding the progression of registrations and audits. (Churches of Christ Life Care, sub. 77, p. 1)

> Building a new national portal, as envisaged by the Commission, would be a major undertaking in its own right, demanding significant investment and long-term transition planning. Unless these

foundations are strengthened first and there is confirmed and consistent funding, an ambitious redesign risks creating more administrative burden rather than streamlining it. (Anonymous, sub. 210, p. 5)

Single set of quality and safety standards

Many submissions supported our draft recommendation for a single set of quality and safety standards. Participants agreed that a modular approach with sector specific standards would be necessary, and some cited current modules in the NDIS as an example.

> We support the introduction of a single (potentially) modular set of practice and quality standards across aged care and NDIS services, provided that it has adequate specialised standards for specific services … The NDIS currently has three different types of modules: core (applies to all registered providers delivering higher-risk supports), supplementary (service specific modules) and verification (all registered providers delivering lower-risk supports). We would endorse a similar approach to a modular set of practice and quality standards. (Uniting NSW.ACT, sub. 114, p. 3)

> combining aged care quality standards and National Disability Insurance Scheme practice standards into a single set, as recommended, will require a modular approach. This means developing core modules that apply universally, supplemented by specific modules tailored to different service types, thereby accommodating the meaningful differences between sectors without compromising overall quality or safety. (HumanAbility, sub. 191, p. 10)

That said, a few participants questioned whether a single set of quality and safety standards would ensure providers meet standards of care for specific groups and result in desired outcomes.

> As specialist care and support providers we question whether a single set of practice and quality standards, or a single provider registration and audit system would or could fully meet the requirements of ensuring that providers are meeting the standards associated with the specialist care for specific populations. However, recognising that there may be many commonalities across population groups receiving care and support, a foundational set of practice and quality standards with specialist modules, and similar registration assessment and audit approaches would simplify the current complex environment. (Australian Psychosocial Alliance, sub. 112, p. 3)

> Aged care has had a single set of standards for residential care and home care since 2019. This has done little to promote services working across both settings. While the rules are broadly the same, the capabilities to deliver quality services in each setting remains substantially different. (Bolton Clarke, sub. 79, p. 2)

Behaviour support plans and restrictive practices

Submissions highlighted the complexity of regulation for the authorisation and reporting of restrictive practices, both between aged care and the NDIS and across jurisdictions.

> There is no consistent national approach to the authorisation and reporting of restrictive practices. Providers must navigate multiple, overlapping regimes, leading to duplicated efforts and confusion. For example, in some jurisdictions, the use of restrictive practices must be authorised and reported to both state/territory authorities and the NDIS Commission. This parallel reporting not only consumes time and resources but also results in fragmented oversight and data inconsistency. (National Disability Services, qr. 85, p. 1)

The need to include the elimination of restrictive practices rather than simply focusing on alignment of regulation was raised.

> The elimination of restrictive practices needs to be included, along with support for decision making, rights-based frameworks and a commitment to non-institutional care. Restrictive practices against people with disability occur in a wide range of settings, including those not funded by the NDIS, and are subject to incomplete regulation and monitoring. The growing use of restrictive practices in NDIS services, schools and prisons highlights that current 'safeguards' are inadequate and must be strengthened to uphold the rights of people with disabilities. (Women with Disabilities Australia, sub. 188, p. 8)

Participants stressed that any changes to the regulation of behaviour support plans and restrictive practices must comply with human rights obligations.

> Aligning regulatory requirements for behaviour support plans and the use of restrictive practices across aged care and the NDIS offers potential benefits, including greater consistency, reduced provider burden, and clearer safeguards for consumers. Alignment would also support consistent compliance with human rights obligations which underpin both NDIS and the new Aged Care Act legislative frameworks, increasing the safeguards to reduce the risk of implementing restrictive practices without lawful consent. (Australian Nursing and Midwifery Federation (ANMF), sub. 87, p. 12)

> Government should develop a National Framework on the Elimination of Restrictive Practices, across all settings, as part of broader regulatory reforms. Regulation of restrictive practices is a human rights imperative and should:

- be aligned with human rights obligations, including those under the [United Nations Convention on Rights of Persons with Disabilities] and the Optional Protocol to the Convention Against Torture and other Cruel, *Inhuman or Degrading Treatment or Punishment* (OPCAT). (Australian Human Rights Commission, sub. 235, p. 11)

Pursuing a single regulator

Many participants provided qualified support for exploring a single care and support regulator and acknowledged it could improve coordination, reduce duplication and streamline oversight, if carefully managed.

> A single regulator could improve coordination and efficiency under one set of standards and provider system, provided sector-specific nuances are preserved and considerations of contextual differences and the needs of actors in different sectors are acknowledged and respected. (ANMF, sub. 87, p. 11)

But some participants did not feel a single regulator should be explored and highlighted the possible risks.

> We have serious concerns that safety standards would drop under a single regulator, with terrible consequences for older people and people with disabilities. A single regulator would also need to report to multiple Ministers, given that in the current Federal Cabinet there are distinct Ministers for Health and Ageing; the NDIS, and for Aged Care and Seniors. (UWU, sub. 199, p. 33)

> While a single regulator can create a more efficient system, there is a significant risk that regulators will not have the cultural safety necessary to evaluate aged care services in remote and very remote areas. (Aged Care Workforce Remote Accord, sub. 109, p. 6)

Principles to underpin alignment of regulation

Participants highlighted that any effort to align regulations should be guided by appropriate principles relevant to the care and support economy. They emphasised that care sector regulation should be human rights-based and the need for appropriate co-design, consultation and collaboration with care users.

Need for human rights-based regulation

Participants strongly suggested that any reform of regulation should integrate human rights principles and person-centred approaches.

> We recommend that the reforms and any recommendations by the Productivity Commission be designed using a firm human rights basis and that ideally, the Australian Human Rights Commission be involved in development of reforms. (Australian Association of Gerontology, sub. 134, p. 5)

> Relationships Australia urges the Productivity Commission to explicitly position human rights at the core of policy, legislative and regulatory reforms to lift productivity. (Relationships Australia, sub. 65, p. 9)

Engagement and person-centred design

Submissions also emphasised the need for genuine engagement to ensure regulations are designed in a person-centred way.

Participants highlighted that the design of regulation should incorporate lived experience, cultural safety, consultation and co-design, as outlined below.

Lived experience

> "Regulatory reform discussions must centre the lived expertise of people with disability, their supporters, and carers to ensure a clear understanding of how any recommendations would operate in practice. (People with Disability Australia, sub. 93, p. 2)"

> "Achieving [regulatory alignment] is best done through embedding lived experience into regulatory design as care participants know where and how the rigid systems fail. Their insights can shape the rules that govern service delivery. (La Trobe University, sub. 216, p.3)"

Cultural safety

> "For Aboriginal and Torres Strait Islander Peoples, 'quality' and 'safety' are defined by the presence of cultural safety. Any reform to align regulation must therefore have cultural safety as its central, non-negotiable tenet. Streamlining processes without embedding cultural safety will fail to deliver quality care. (Gayaa Dhuwi (Proud Spirit) Australia (Gayaa Dhuwi), sub. 167, p. 3)"

> "Alignment of care sector regulations should also see the incorporation of cultural safety requirements such as those included in Aged Care sector reforms. (NACCHO, sub. 215, p. 15)"

Consultation

> Any significant change to regulation that impacts safety and quality should involve substantial consumer consultation, particularly for culturally and linguistically diverse groups who can be at higher risk of safety events due to language and cultural barriers. (Australian Institute of Health Innovation, sub. 249, p.3)

> We strongly recommend that … consultative processes are accessible, trauma-informed and culturally safe – including the provision of Easy Read materials. (Inclusion Australia, sub. 117, p. 2)

Co-design

> All elements of reform – standards, systems, registration, and reporting – must be co-designed with people with disability, their families, carers, and service providers. This ensures cultural safety, relevance, and practical feasibility. (NDS, sub. 241, p. 6)

> Mandate that any reform of quality and safety regulation is co-designed and governed with Aboriginal and Torres Strait Islander leadership, embedding cultural safety as a core, measurable, and enforceable standard for all care providers. (Gayaa Dhuwi, sub. 167, p. 4)

Risk-proportionate and outcomes-based approach

Participants highlighted the importance of moving towards regulation in the care economy that is both risk-proportionate and outcomes-based. They emphasised that regulation should be linked to the level of risk and improve the outcomes of care users.

> The care economy has a valuable opportunity to adopt risk-based, adaptive regulation, moving beyond traditional frameworks that are often binary and static, focused solely on compliance with minimum standards. Instead, regulation should enable dynamic assessment of risk and performance, better reflecting the complexity and diversity of care delivery. A risk-based approach would allow regulatory effort to be proportionate to the actual risk posed by a provider or service. (Catholic Health Australia, sub. 165, p. 10)

> The need to reorient towards a person-centred, outcomes-focused approach to the harmonisation of safety and quality regulation is paramount in addressing what are real-world consequences for patient outcomes, system efficiency, and workforce sustainability. (Australian Healthcare and Hospitals Association, sub. 26, p. 7)

Implementation

A number of issues around the implementation of a program of regulatory alignment were raised. Participants raised concerns about the timelines for implementing the proposed recommendations, given the reform fatigue being experienced across care sectors.

> As the Interim Report acknowledges, the changes are proposed within a care sector that is already undergoing significant reforms. These changes would, in some cases, interact with or change reforms in which the care sector has already invested significantly in implementing. In the aged care sector in particular, there is considerable change fatigue, uncertainty, and anxiety among both providers and care users, even though the need for change is well acknowledged. (Australian Association of Gerontology, sub. 134, p. 3)

> We recognise the significant reform-fatigue and pressure faced by care economy providers and respectfully request a reasonable approach to future reforms, noting the reform proposed is estimated to occur between the next three to six years. (Care Economy CRC, sub. 232, p. 1)

And some participants wanted to see existing reforms being progressed, prior to pursuing a regulatory alignment agenda.

> In our view, alignment should not pause or replace reforms already underway. Instead, governments should prioritise completing existing reforms on time and consolidating them into a more cohesive system. Incremental alignment through shared systems, mutual recognition, and harmonised standards can deliver efficiency without undermining sector-specific safeguards or risking further delay. (Anonymous, sub. 210, p. 6)

Finally, some submissions emphasised the need for strong leadership to drive the reforms.

> To ensure momentum is maintained, prioritise regulatory alignment across the care economy, and:
>
> - identify a lead agency that has sufficient authority to bring government agencies together to progress the alignment agenda.
> - establish a care and support economy advisory group, comprised of sector leaders across the care economy, to advise this lead agency.
> - further consult on, test and evaluate the actions, proportionate to risk and impact.
> - publish timelines and regular progress updates. (Ageing Australia, sub. 161, p. 10)

Embed collaborative commissioning to increase the integration of care services

We looked at how governments could embed collaborative commissioning – where organisations work in partnership to plan, procure and evaluate services – to support more integrated care, tailor care to local needs and foster new innovative models of care. This reform focuses on improving governance and funding arrangements to support better collaboration between Local Hospital Networks (LHNs) and Primary Health Networks (PHNs), in partnership with Aboriginal Community Controlled Health Organisations (ACCHOs) and other organisations. The focus of our engagement was to understand the key barriers to and enablers of collaborative commissioning, to receive feedback on the proposed reform and gather examples of collaborative commissioning and its impact. The key themes from engagement are outlined below.

Benefits of collaborative commissioning
Improved outcomes and a more integrated system of care

Collaborative commissioning can tailor services to local needs
Collaborative commissioning can support a place-based approach

Barriers to collaborative commissioning
There are a range of barriers to collaborative commissioning

Addressing the barriers to collaborative commissioning
The need for a package of reforms to overcome barriers

Benefits of collaborative commissioning

Participants outlined a wide variety of benefits of collaborative commissioning, including improved productivity and healthcare outcomes, greater innovation and learning and facilitating more integrated care.

Many participants raised improved productivity and resource efficiency through less overlap and duplication in planning and health service delivery, and the delivery of programs that better meet local health needs.

> By planning together we can make the most out of the limited public funds available by ensuring the funds are spent where they are most needed. Shared data analysis and planning functions reduce duplication and costs … (The Health Alliance, a joint initiative between Metro North Health and Brisbane North PHN (The Health Alliance), qr. 70, p. 2)

Submissions also raised improved health, healthcare outcomes and patient experiences as benefits. These included improved transitions from hospital to home, reduced avoidable hospital admissions, better care for patients with chronic and complex health conditions and improved continuity of care.

Benefits were highlighted through examples of collaboratively commissioned programs. For example, Murrumbidgee Primary Health Network (qr. 89, p. 2) noted the benefits of its program Living Well, Your Way.

> More than 2500 patient reported outcome measures have been collected … all three showed improvements after participation in care along the pathway. Local data estimates that since 2018, triage 3-5 ED presentations for people with [Chronic obtrusive pulmonary disease] and [Congestive heart failure] in Murrumbidgee has reduced by 18% and hospital admissions have reduced by 37%.

Some participants raised greater innovation and learning resulting from collaborative commissioning.

> Partnerships promote innovation through shared data and data transparency, co-design processes, and mutual learning. (Australian Healthcare and Hospitals Association (AHHA), sub. 26, p. 11)

> Continuous, shared learning is enabled by collaborative commissioning because the governance body can bring together best practice from the various actors involved and then share those learnings across the collaboration. (Centre for Policy Development (CPD), qr. 96, p. 4)

Participants also raised how collaborative commissioning can help overcome systemwide health challenges and support a more integrated approach to care.

> 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)

> Working together to plan and commission services allows us to design a health system that is integrated and seamless for the patient. We are better [able] to ensure the right services are available at the right time and in the right place. We can ensure that all parts of the health system are aware of and can interact with each other. (The Health Alliance, qr. 70, p. 3)

Collaborative commissioning can tailor services to local needs

Participants highlighted that collaborative commissioning can support local-decision making and take a place-based approach, where services are tailored to meet local priorities, conditions and needs. We heard that place-based approaches to care can support accountability for outcomes and that centralised governance and system structures are barriers to implementation. Examples that highlight place-based approaches are included below.

What we heard about place-based approaches to care

> "to maximise its [collaborative commissioning's] potential to deliver more effective, enduring outcomes, this model should take a strategic and place-based approach that engages local stakeholders and responds to community-specific needs. (Mallee Family Care, sub. 73, p. 6)"

> "These geographic localities enable place-based partnerships to act as shared governance mechanisms to assess local need, identify service gaps, and co-design integrated care models that reflect local priorities and conditions. The model enables shared accountability for outcomes, rather than activity, and supports flexible, locally relevant solutions that improve access, continuity, and value in care. (AHHA, sub. 26, p. 8)"

> "Australian communities are marked by considerable diversity and are distributed across a vast geographic area. … Effective and sustainable placed-based work often arises from locally driven research evidence with a focus on lived experience … (Sydney Policy Lab, The University of Sydney, sub. 76, p. 3)"

> "Commissioning that genuinely brings together governments, providers, and communities, including private industry, has the potential to … ensure place-based responses to health needs. … [yet] centralised governance risk[s] undermining this reform. (St Luke's Medical and Hospital Benefits Association Ltd, sub. 238, p. 1)"

Community at the centre of collaborative commissioning

Submissions, especially following the release of the interim report and from peak bodies, often discussed the importance of community engagement in the process of collaborative commissioning. Some participants highlighted that communities should not only be involved in consultation, but as leaders and partners in change.

> People with lived experience should be actively involved in decisions that affect them. Their participation helps ensure policies are inclusive, intersectional and uphold the human rights of diverse groups. (Australian Human Rights Commission, sub. 235, p. 7)

Participants called for engagement with GPs, clinical experts, workforce representatives, multicultural health organisations, community organisations, disability-led and women's health organisations, among others. Some participants raised formal relational contracting as a mechanism to support cooperation and collaboration with service providers in the commissioning process.

> [Formal relational contracting] is essential to ensuring genuine collaboration with service providers throughout the entirety of this cycle, particularly ongoing information sharing and reciprocal feedback that can be used to shape service design. (CPD, sub. 244, p. 7)

Place-based approaches and the Aboriginal Community Controlled Health sector

Submissions highlighted that Aboriginal Community Controlled Health Organisations (ACCHOs) embody a successful integrated place-based approach.

> 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. (National Aboriginal Community Controlled Health Organisation (NACCHO), sub. 32, p. 10)

> PHNs and ACCHOs are … establishing, funding, designing and governing place-based, wraparound hub models of care … Child and Family Hubs operating across Australia serve as vital "front doors" for families seeking a range of coordinated supports, such as Cullunghutti Aboriginal Child and Family Centre … Evaluations of hub models has shown improved access, equity and continuity for children and families facing adversity. (Minderoo Foundation, Thrive by Five, sub. 145, p. 5)

NACCHO (sub. 215, p. 3) also raised the need to transition funding for Aboriginal and Torres Strait Islander programs and services from PHNs to ACCHOs.

> NACCHO recommends funding for provision of health and care services to Aboriginal and Torres Strait Islander people, is transitioned from PHNs to the ACCHO sector, in line with Priority Reforms 2 and 3, and actions recommended under the Primary Health Care 10 Year Plan.

Barriers to collaborative commissioning

Participants raised a range of barriers to collaborative commissioning, especially in questionnaire responses. Frequent barriers that participants raised included:

- fragmentation and misalignment that limits shared accountability and incentivises cost shifting
- short-term funding that inhibits partners developing trust and planning together long-term
- inflexible funding that limits collaboration and the delivery of services that meet local health needs

- data and evaluation constraints that impede opportunities to identify joint needs and evaluate joint programs
- capability constraints that hinder the ability to effectively collaborate and co-design.

Examples for each barrier are outlined below.

Fragmentation and misalignment

> "Procurement processes are often siloed, with limited mechanisms for joint planning or shared accountability. This fragmentation makes it difficult to align funding, service design, and outcome measurement across sectors such as health, disability, and aged care. (Medical Technology Association of Australia, qr. 63, p. 6)"

> "fragmented arrangements create incentives to shift costs rather than share them, with each player accountable for its own budget and outcomes rather than the overall wellbeing of the person or population. (Catholic Health Australia, qr. 65, p. 7)"

> "Even where there is strong local commitment to collaboration, structural funding splits … can gradually erode alignment of priorities. (The George Institute for Global Health and the Leeder Centre for Health Policy, Economics and Data, qr. 72, p. 5)"

Short-term funding

> "Short-term funding cycles and frequent shifts in policy direction, often tied to changes in government, undermine the stability needed for effective collaborative commissioning. Two-year funding cycles are common, limiting the ability of lead organisations and service partners to plan long-term, build trust, invest in workforce development, and evaluate impact. (Fixing the NDIS research team, Centre for Disability Research and Policy, The University of Sydney, qr. 31, p. 6)"

Inflexible funding

> "the current infrastructure for commissioning for PHNs, where they are allocated a relatively small amount of flexible funding to prioritise across all local population health needs, is a barrier preventing collaborative commissioning … (National Centre of Excellence in Intellectual Disability Health, qr. 80, p. 4)"

Data and evaluation constraints

> "Siloed and inaccessible, or non-transparency of data makes it difficult for commissioners and providers to identify allocation and availability of funding, shared priorities, monitor population outcomes, or track the impact of investment across care pathways. (AHHA, sub. 26, p. 11)"

> "Limitations in data sharing, and lags in availability of data for platforms that are available (such as Lumos), which make it difficult to quantify outcomes in short timeframes … (Murrumbidgee Primary Health Network, qr. 89, p. 3)"

Capability constraints

> "A major challenge is the inconsistent capability of lead commissioning organisations … (Fixing the NDIS research team, Centre for Disability Research and Policy, The University of Sydney, qr. 31, p. 5)"

> "despite existing expectations that LHNs and PHNs work closely together around planning that current capability, interest and capacity amongst the players varies significantly. (Australian Psychological Alliance, sub. 112, p. 4)"

Addressing the barriers to collaborative commissioning

Participants were broadly supportive of draft recommendation 2.1 for a package of reforms, both new joint governance arrangements and changes to funding arrangements, to overcome the barriers to successfully implement and embed collaborative commissioning.

> For Collaborative Commissioning to succeed, governance must be genuinely collaborative, with a balance of influence across stakeholders. In parallel, system planners and funders must ensure the right incentives and supports are in place to help providers transition to new ways of working. Ongoing evaluation will be critical to identify which models most effectively promote trust, alignment, and lasting service transformation. (The George Institute for Global Health and The Leeder Centre for Health Policy, Economics and Data, qr. 72, p. 5)

Joint governance arrangements to underpin collaboration

Most participants raised and supported new joint governance arrangements and requirements for LHNs, PHNs and ACCHOs to jointly plan together. Participants highlighted how this would support whole-of-system responsibility and accountability, build trust and collaborative relationships and support the move towards genuine co-design. Key governance mechanisms raised by participants included well-defined roles and responsibilities, shared objectives, joint committees and joint needs assessments.

> a joint governance framework must cover the entire planning cycle from needs assessment and planning, through funding and implementation, to evaluation and review … (PHN Cooperative, sub. 104, p. 6)

Shared outcomes framework to support accountability

Participants frequently raised the need for a shared outcomes framework to support joint accountability and incentivise long-term improvements in health outcomes, rather than short-term outputs. This included embedding outcome-based contracting, the alignment of performance frameworks across different funding bodies and the development of a single outcomes framework.

> Align performance frameworks across funding bodies to support shared outcomes rather than siloed outputs. (The Benevolent Society, qr. 73, p. 6)

Participants raised the quintuple aim of care, which aligns with the 'pursuit of productivity while ensuring individual health outcomes, population health uplift and health professional wellbeing' (Australasian Institute of Digital Health, sub. 195, pp. 2–3). Participants also considered the need to develop the framework with stakeholders so that outcomes reporting on joint commissioning activities is not an additional administrative burden.

> An outcomes framework to support joint monitoring and reporting is a good idea, however this would need to be agreed by federal and state governments and be comprehensively used. (The Health Alliance, sub. 84, p. 6)

Participants also noted the need for regional flexibility in agreed outcomes.

> The framework should identify core outcomes … and allow for secondary outcomes to be developed at a regional level specific to place-based needs and priority populations … (PHN Cooperative, sub. 104, p. 7)

Shared decision making with Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander organisations raised governments' commitments under the National Agreement on Closing the Gap, including to shared decision-making with Aboriginal and Torres Strait Islander people, and the need for this to be part of collaborative commissioning governance, planning, decision making and evaluation.

> IAHA recommends: making ACCOs equal partners in governance, planning, and evaluation under collaborative commissioning frameworks, in line with Closing the Gap Priority Reforms. (Indigenous Allied Health Australia Ltd, sub. 155, p. 4)

> Strengthen the recommendation on collaborative commissioning by mandating that ACCHOs are resourced and recognised as equal partners in governance, planning, and decision-making, in line with Priority Reform One of the National Agreement on Closing the Gap. (Gayaa Dhuwi (Proud Spirit) Australia (Gayaa Dhuwi), sub. 167, p. 4)

Capability uplift and data sharing arrangements to enable reform

Participants highlighted the need for supporting governance reforms to overcome capability and data and evaluation constraints.

Many participants raised organisational capability uplift as necessary to embed collaborative commissioning.

> new leadership qualities will be required to lead and sustain collaborative commissioning in the long-term. (Health Consumers' Council WA, qr. 48, p. 3)

Submissions discussed a variety of options, including shared learning mechanisms (for example, CPD (sub. 244, pp. 6–7) and a systematic approach to strengthen capability.

> We suggest the Commission recommend a systematic program to build commissioning capability in federal and state departments, and PHNs. This should be informed by assessment of optimum governance and funding settings, performance measurement approaches, current commissioning capabilities, and international best practices. (Grattan Institute, sub. 71, p. 4)

Participants frequently mentioned data sharing arrangements and data interoperability as necessary to embed collaborative commissioning, to support the identification of key health needs, the evaluation of programs and system performance and accountability. Many participants mentioned the need for investment in digital infrastructure, agreement forming and capacity-building.

> Australia does not have large scale infrastructure and processes in place for linked data. This prevents health policy makers and providers from understanding how well the health system performs and identifying policy solutions to improve the patient journey and health outcomes. (The George Institute for Global Health and The Leeder Centre for Health Policy, Economics and Data, qr. 72, p. 5)

> local arrangements take a lot of time and resources to develop and would benefit from standard agreements … and dedicated funding … Improved data sharing from other sources within the health system and beyond would also create a better and fuller picture of local needs, facilitate greater patient care and allow more robust monitoring and evaluation. (The Health Alliance, qr. 70, p. 4)

Long-term, secure funding and flexibility to enable collaboration

Participants identified short-term and inflexible funding as key barriers to embedding collaborative commissioning. Participants highlighted that longer-term, secure funding that is integrated into health and care systems would enable greater collaboration and improve trust and organisational capacity.

> Funding certainty of at least 5 years should be provided … (The Health Alliance, qr. 70, p. 3)

> place-based approaches to care need to be funded by Government – with a shift from positioning these as either pilots or proof of concept, to being locally validated and integrated into health and care systems. (Sydney Policy Lab, The University of Sydney, sub. 76, p. 3)

> ongoing funding, rather than start-stop programs will ensure trust and involvement. (The National Rural Health Alliance, qr. 97, p. 2)

In addition, submissions identified flexibility, often together with secure funding, as important to enable collaborative commissioning – enabling organisations to determine what programs best meet local needs.

> "flexible funding" must be genuinely flexible and long-term. The current reliance on short-term, prescriptive funding cycles constrains the capacity of our organisations to plan effectively and build sustainable services. (Gayaa Dhuwi, sub. 167, p. 3)

Some participants highlighted the need for increased funding autonomy to be matched with accountability.

> We support making ongoing funds for local governance and collaborative commissioning conditional on delivering ongoing outputs and outcomes. (The Health Alliance, sub. 84, p. 7)

New dedicated joint funding for local needs and collaboration

Participants supported new dedicated funding, for both new collaboratively commissioned programs (for example, Royal Australasian College of Physicians (qr. 64, p. 5)) and operational needs, including to set up and maintain collaborative arrangements.

> LHNs and PHNs each already have staff and resources that deliver all of the stages of the commissioning cycle. However, this primarily focuses on their own internal planning purposes. Joint commissioning often happens on top of this, using (stretching) those existing resources. (The Health Alliance, sub. 84, p. 6)

Participants discussed the level of resourcing required in post-interim submissions in response to information request 2.2 in the interim report (see also: Murrumbidgee Local Health District and Murrumbidgee Primary Health Network (MLHD/MPHN) (sub. 240, pp. 1–2); The Health Alliance (sub. 84, pp. 6–7)).

> The levels of resourcing required to support enhanced joint governance requirements is likely to vary from region to region, particularly for PHNs. A critical factor for the level of PHN governance funding will be the number of LHNs with whom the PHN needs to collaborate …

> The level of dedicated funding for joint service delivery required will also depend on factors like rurality, socioeconomic demographics of the region, population and any workforce shortages as well as the scale of the problem … (PHN Cooperative, sub. 104, p. 8)

Outcomes-based funding

There were a range of views on outcomes-based funding or funding adjustments, with some participants expressing support. However, in response to our interim report, some participants, especially research and

policy institutes and academics, had concerns with potentially preventable hospitalisations as an initial outcome to base funding adjustments (for example, Grattan Institute (sub. 71, pp. 2–3)).

Some participants also considered the unintended consequences of funding adjustments, if local factors were not adequately considered.

> outcome-based funding may create financial uncertainty, and funding models will need to ensure equity for disadvantaged regions … (Australian Association of Gerontology, sub. 134, p. 7)

And the potential for gaming, if not designed appropriately.

> outcomes-based funding is … vulnerable to providers gaming the system to maximise the funding they receive at the expense of service quality or service user wellbeing. (CPD, sub. 244, p. 7)

To address issues with outcomes-based funding, CPD (sub. 244, p. 8) suggested a focus on learning at the centre of commissioning and recommended using evidence and the ongoing iteration in the design of performance indicators. In response to a funding adjustment based on potentially preventable hospitalisations, some participants suggested utilising a broader set of performance measures, whether for funding adjustments or performance reporting.[1]

Opportunities to extend collaborative commissioning

Many submissions discussed the opportunity for collaborative commissioning to be integrated into health and care systems and to extend the scope to include other service types, such as disability services and aged care, and other partnerships, including service providers and government departments.

> [Collaborative commissioning] can deliver significant productivity benefits in metropolitan areas, and also for regional and rural areas that experience thinner markets and greater gaps in service provision … explore the feasibility of extending the productivity gains from collaborative commissioning beyond health, to early childhood, Foundational Supports and aged care. (The Brotherhood of St. Laurence, sub. 180, p. 3)

Barriers to success

Most participants supported draft recommendation 2.1 to embed collaborative commissioning. However, some submissions noted concerns, including that barriers may inhibit collaborative commissioning from being implemented effectively and achieving its goals.

> it is unclear whether collaborative commissioning involving PHNs, LHNs and ACCHOs will produce large productivity gains given the complexity in developing, managing and evaluating commissioning processes at a local level. (Health Economics Collaboration, sub. 250, p. 8)

Some participants also viewed formal relational contracting as higher priority or necessary to embed collaborative commissioning.

> Collaborative Commissioning is most likely to deliver the expected benefits if these arrangements embrace Formal Relational Contracts and so Formal Relational Contracts should be a first step towards Collaborative Commissioning. (Melbourne Disability Institute, Australian Welfare and Work Lab - University of Melbourne, sub. 107, p. 3)

[1] For example, Grattan Institute (sub. 71, p. 2); MLHD/MPHN (sub. 240, p. 2); The George Institute for Global Health (sub. 154, p. 6).

A national framework to support government investment in prevention and early intervention

Stopping problems from starting or from getting worse can result in better social and economic outcomes for individuals and the community. Investing in effective prevention can also reduce demand for more costly services in the future and help limit growth in Australian, state and territory governments' expenditure.

The interim report invited feedback on a proposed framework to provide governments with greater incentives to invest in prevention and early intervention. We sought information about barriers to investing in prevention and early intervention, gathered examples of effective prevention and early intervention, invited ideas for solutions, and provided an opportunity to respond to the draft recommendation. The key themes from engagement are outlined below.

Investing in prevention and early intervention
Investment in prevention is expected to provide social and economic benefits

Evidence and evaluation
Difficulties with evidence and evaluation are recognised as a barrier to investment

Funding prevention and early intervention
There is a need to improve the way that prevention and early intervention are funded

Whole-of-government action
Effective prevention and early intervention requires a whole-of-government perspective

Investing in prevention and early intervention

Many submissions reflected on the importance of better investment in prevention to produce a range of benefits at the individual, community and economy-wide level.

> A more structured approach to prevention could yield benefits across healthcare, justice and [the] social welfare system. (Department of Social Services, sub. 254, p. 1)

> making an investment in improving future health outcomes for Australia's younger generations, should be reason alone and reason enough for all levels of government to lift their investment in prevention. (HealthWISE, sub. 111, p. 3)

> Australia now stands at a decisive juncture: continue a costly crisis response or pivot towards prevention-first models that maximise social and economic returns. Without decisive investment in prevention … entrenched disadvantage will deepen social fractures and drive-up long-term costs. (Sydney Policy Lab, The University of Sydney, sub. 76, p. 6)

Participants saw prevention and early intervention initiatives as an opportunity to improve outcomes for priority populations and address disadvantage.

> high-quality prevention programs deliver both immediate and long-term benefits. These extend from reducing government expenditure on acute services … to enhancing life opportunities for the most vulnerable Australians. (Minderoo Foundation, Thrive by Five, sub. 145, p. 7)

> Prevention has particular benefits for multicultural communities, who face … additional barriers to care. (Australian Multicultural Health Collaborative, sub. 156, p. 5)

> The payoff will be substantial: improved preventive care for people with disability can lead to longer, healthier lives and reduce costly acute care … (JFA Purple Orange, sub. 237, p. 21)

But participants also recognised the systemic challenges of incentivising prevention and early intervention.

> The challenge is not proving prevention works - it is designing a governance and funding mechanism that ensures prevention is prioritised, sustained, and scaled. (KPMG Australia, sub. 115, p. 8)

> Prevention is not always a path towards reduced costs. There is often a substantial cost associated with implementing large scale prevention … because of the sheer number of people to reach, but also the difficulty in changing people's behaviour. A prevention program that increases costs but generates commensurate improvements … also has an economic case to proceed. (Health Economics Collaboration, sub. 250, p. 11)

The definition and scope of 'prevention'

Participants expressed a range of views on the definition of prevention and early intervention, and many participants sought a greater focus on primary and primordial prevention.

> Including [primary, secondary and tertiary prevention] may reinforce current thinking and perception that primary prevention is less urgent, and more risky when compared to secondary and tertiary prevention, despite offering excellent value for money. (Deakin Health Economics, Deakin University (DHE), sub. 61, p. 1)

Many participants also encouraged greater focus on the determinants of health.[2] Some suggested specific areas to broaden the reform scope to include, urban planning (The Australian Prevention Partnership Centre (Prevention Centre), sub. 129, p. 5; Exercise and Sports Science Australia, sub. 119 attachment A, p. 11; Quality for Outcomes, sub. 62, pp. 3–4), indoor air quality (Australian Academy of Science, sub. 233, p. 5; Burnet Institute, sub. 144; The Safer Air Project, sub. 131), climate change management (Public Health Association of Australia (PHAA), sub. 97, p. 5; Research Australia, sub. 202, p. 10) and arts, creativity and social prescribing (Creative Australia, sub. 257, pp. 1–3).

> prevention initiatives employed by governments should expand beyond the care economy and integrate a range of policy areas … because many of the factors shaping demand on the care sector sit outside of the care sector itself. (Centre for Policy Development (CPD), qr. 96, p. 9)

[2] More than 50 participants said this, including Australian Health Promotion Association (sub.125, p. 5), Australian Human Rights Commission (sub. 235, p. 12) and National Aboriginal Community Controlled Health Organisation (NACCHO) (sub. 215, p. 17).

Multiple organisations indicated the scope should include system wide prevention interventions.

> the interim report focuses heavily on programs, while underplaying structural interventions such as taxation, regulation and fiscal measures, which are among the most effective, equitable, cost effective and sustainable forms of prevention. (Prevention Centre, sub. 129, p. 5)

Alternatively, some participants advocated for a narrower, health focused, definition of prevention focused on later stage tertiary and secondary prevention. Participants also commonly referenced programs for hospital-based interventions, dental care, GP services, vaccines and cancer screening.

Despite definition nuances, participants provided over 100 prevention and early intervention examples and identified a variety of opportunity areas including, health and mental health, early childcare, justice and housing.

Evidence and evaluation

Participants cited evidence and evaluation processes as a barrier to government investment in prevention.

> Prevention efforts are systematically limited by inconsistent evaluation methods and fragmented data systems … (Wellbeing and Prevention Coalition in Mental Health, qr. 74, p. 2)

> The challenge is to accept that uncertainty is inherent and to focus on what can be reasonably measured in the early years. Balancing the assessment of early effectiveness with the need for consistent long-term funding … relies on judicious use of short-term indicators while maintaining a commitment to longer-term outcomes and investment. (Cancer Council Australia, sub. 127, p. 7)

Participants intimated that the cross-sectoral and long-term nature of prevention benefits can limit generation of evidence and the willingness of government to support programs with medium to long term benefits.

> we are firm believers that effective early intervention and prevention is good policy; and that there are many opportunities missed because evidence is slow to emerge, or benefits might accrue to different departments and tiers of government. (Taylor Fry, sub. 184, p. 2)

> Prevention, by nature, requires time to track and assess outcomes — often beyond the typical one-to-three-year funding horizon. Without the ability to demonstrate long-term impacts, services are caught in a cycle where they are unable to build the evidence base required to justify future funding. (The Benevolent Society, qr. 73, p. 6)

> Without strong, cross-sectoral evidence, policymakers lack the tools to make integrated, whole-of-government investment decisions in prevention. If the evidence itself is siloed, how can it meaningfully inform cross-sectoral policies? (Fixing the NDIS research team, Centre for Disability Research and Policy, The University of Sydney, qr. 31, p. 7)

A framework to support effective evaluation

Participants strongly supported a framework to aid evidence-based decision making and guide consistent evaluation of prevention and early intervention initiatives, as outlined in draft recommendation 3.1.

> a national prevention framework can also provide a vital tool to reorientate how government invests in Australia's future by moving away from a focus on short-term outcomes to align productivity with intergenerational fairness, higher standards of living and health and wellbeing for all Australians. (Victorian Health Promotion Foundation (VicHealth), sub. 103, p. 6)

While opinions varied on the elements required in a framework and their prioritisation, feedback commonly recognised a need for flexibility in how different prevention and early intervention options may be prioritised.

> Although a major potential benefit of the proposed framework is promoting consistency in evaluation and decision-making, we recommend that the framework strike a balance between standardising some methods … and allowing flexibility for decision-makers to explore alternative weightings of decision criteria. (Health Economics Group, School of Public Health and Preventive Medicine, Monash University (HEG), sub. 243, p. 3)

Participants also provided many suggestions when reflecting on the diversity of programs to be supported.

> [The Framework] should balance investment across different risk factors, sectors, populations impacted (including priority populations), magnitude of investment across government sectors and tiers, and levels of risk (taking a portfolio approach where high-risk high-reward investments are balanced with low-risk low-reward strategies (that still produce net benefits). (DHE, sub. 61, p. 3)

When reflecting on how assessment criteria should be weighted, some participants referenced established frameworks, while other participants provided their own suggested priorities. Participants often specified a cohort or issue to prioritise but there was no unanimous priority among participants.

Linked data and modelling capability

Participants recognised the importance of data linkage and access to support the modelling of benefits and building of evidence. While many participants recognised the importance of data use and improvement, there were a variety of views about the current barriers, benefits and process for improvement. Responses also centred on the unintended consequences of relying on data, including bias or inaccuracies.

Improving current data systems and access

> it is harder to build a case for investment in prevention when there is insufficient data on which to build that case. (National Eating Disorders Collaboration, qr. 54, p. 3)

Data supports the use of long-term outcome models

> Securing rapid access to high-quality, deidentified data is critical for governments to monitor, evaluate and refine outcomes-based preventive health investments, ensuring non-monetary intermediate impacts are measured and valued alongside long-term gains. (Cancer Council Australia, sub. 127, p. 8)

Important data and modelling considerations

> Microsimulation models rely heavily on administrative data ... datasets do not always provide the answers we seek. For example, cessation of mental health services may be a positive outcome (if a person has improved …) or poor (if their health has not improved but they have stopped treatment for other reasons). (Taylor Fry, sub. 184, p. 5)

Improving current data systems and access

> strengthening integrated data systems, that include equity-focused and real-time data, would support scaled action, enable comprehensive tracking of prevention efforts, and highlight gaps. (The Australian Prevention Partnership Centre, qr. 86, p. 8)

> Facilitate access to linked administrative datasets to support evaluation … data must be across departments and jurisdictions to break down data-siloing and ineffective reporting. (Australian Medical Association (AMA), sub. 94, p. 9)

Data supports the use of long-term outcome models

> the [actuarial] model [should] be developed as an open-source resource that is maintained and routinely updated. In addition to providing a practical means of helping the wider prevention program evaluation community adopt consistent approaches, more widespread use of the actuarial model will lead to it being more comprehensively tested and help support innovation … (HEG, sub. 243, p. 6)

Important data and modelling considerations

> Predicting future outcomes, costs and benefits based on … data, if non-representative, can lead to inaccuracies and embed inequities. (Seer Data & Analytics, sub. 53, pp. 7–8)

> [evaluation] methods must be applied with caution, acknowledging limitations in generalisability … (Catholic Health Australia (CHA), sub. 165, p. 42)

Participant support for greater modelling capability was often conditional on embedding equity in the evaluation framework.

> the Framework will only achieve its intended outcomes - improved population health, reduced demand for acute care, and sustainable expenditure - if it explicitly embeds multicultural quality and equity standards. Without these, prevention strategies risk widening, rather than narrowing, existing health inequities. (La Trobe University, sub. 216, p. 1)

Some participants also emphasised co-designing the framework with priority groups, stressing the value of genuine engagement, formal partnership and place-based considerations when delivering funded programs.

> ensuring that communities, particularly priority populations, are genuinely involved through co-design … is essential. Without this … the Framework risks overlooking the very partners best placed to drive sustainable and equitable change. (Prevention Centre, sub. 129, p. 8)

Priority cohorts referenced by participants included (but were not limited to) Aboriginal and Torres Strait Islander people, culturally and linguistically diverse (CALD) communities, refugees, people with disability, rural communities, women and LGBTIQ+ communities.

Funding prevention and early intervention

Many participants expressed concern about underinvestment and current prevention funding mechanisms.

> Although targets have been previously discussed … actual Federal government investment in prevention has consistently fallen short. (Public Health Genomics, Monash University, sub. 246, p. 1)

> Without a stable funding base, prevention remains vulnerable to political cycles, short-termism, and fragmented program delivery. (Deakin University's Faculty of Health; Institute for Physical Activity and Nutrition; Institute for Health Transformation; SEED Centre for Lifespan Research, qr. 69, p. 3)

Participants overwhelmingly supported changes to funding levels and infrastructure to support long-term investment. Feedback reflected a diversity of suggestions for funding of prevention and early intervention.

Set a dedicated funding stream aside for prevention

> "A dedicated National Prevention … Fund with a long-term horizon is essential … (Members Health Fund Alliance, sub. 214, p. 14)"

> "Ring-fence and legislate long-term funding to provide stability and protect prevention investment from political cycles. (KPMG Australia, sub. 115, p. 8)"

> "The Framework should have a ring-fenced budget line, offered for multiple years to enable long-term planning. (Minderoo Foundation, Thrive by Five, sub. 145, p. 7)"

Link funding to demonstrable program outcomes

> "Block funding models that seek outcomes … support community-led approaches which … deliver better results. (NACCHO, sub. 215, p. 17)"

> "For example, "progressive funding tranches" could release additional investment as programs meet agreed developmental or implementation milestones. (CHA, sub. 165, p. 47)"

> "linking funding directly to outcomes … can create powerful incentives for innovation … rewarding providers who deliver measurable value. (St Luke's Medical and Hospital Benefits Association Ltd, sub. 238, p. 12)"

Explore the potential to dedicate funding streams to certain aims or priorities

> "We recommend there be an Innovation Fund attached to the Investment Fund … (Silverchain Group, sub. 204, p. 4)"

> "there needs to be a proportion of all funding allocated to sufficiently resource evaluation activities. (Injury Matters, sub. 54, p. 3)"

> "A dedicated funding stream should be established for CALD-focused and other priority population prevention initiatives. (La Trobe University, sub. 216, p. 2)"

Establish a mechanism to support the continuity of funding

> "benefits accrued from investments [should be] reinvested to increase and sustain impact overtime … (Mission Australia, sub. 153, p. 7)"

> "revenue streams could include levies or excise on tobacco, alcohol and sugar-sweetened beverages, consistent with international practice … (Prevention Centre, sub. 129, p. 12)"

> "all new spending proposals in the care economy [should] include a mandatory requirement to allocate five per cent of the proposed expenditure to cross-sector prevention initiatives. (Ageing Australia, sub. 161, p. 4)"

Many participants advocated for new funding, highlighting that without new funding the framework could interfere with existing program investments or funding of acute services.

> Ensuring maintenance of effort, so that new federal funding complements, rather than replaces, existing state and local investments in prevention. (Mallee Family Care, sub. 73, p. 9)

> At the same time, governments and communities have built strong foundations through existing programs … the Framework should complement and reinforce these initiatives using additional funding sources and should not replace them. (VicHealth, sub. 103, p. 17)

> cost savings delivered by preventative health will not be seen for some years, so it is crucial that in the first instance the funding that is available for preventative health … does not reduce the funding available to the health system. (Health Consumers' Council WA, sub. 110, p. 6)

Some participants supported changes to the budget process operational rules, including embedding a prevention mechanism in the Budget and including second-round effects in policy costings.

> To support [Prevention Framework Advisory Board] recommendations, changes to budget operational rules are required. These must include dedicated budget pathways that establish a stream or fund for prevention proposals assessed by PFAB, with multi-year funding commitments. These pathways must be backed up by appropriate reporting … (AMA, sub. 94, p. 8)

Submissions also reflected on how the national framework could work across jurisdictions and supported implementation commencing immediately. However, some participants did not agree with the involvement of states and territories in the initial stages of the reform.

Benefits of a cross-jurisdictional framework and co-funding agreements

"[Co-funding] ensures that all jurisdictions have a stake ... and provides a mechanism for supportive engagement and program delivery … State and territory initiatives demonstrate commitment and support amongst jurisdictions to prevention programs and initiatives that could potentially be scaled up with improved coordination and funding at the national level. (The George Institute for Global Health, sub. 154, pp. 9–10)"

"VicHealth strongly supports the proposal for collaboration … noting the opportunity to co-fund. … This could lead to opportunities for ... reducing duplication across borders. (VicHealth, sub. 103, p. 10)"

Multiple options to support cross-jurisdictional reform

"states and territories bear most short-term costs of late intervention while the Commonwealth reaps long-term savings … therefore include co-funding formulas that rebalance incentives and support sustained state–Commonwealth investment … (Indigenous Allied Health Australia Ltd, sub. 155, p. 6)"

"Formalise roles and responsibilities through an intergovernmental agreement … to ensure accountability and continuity. (AMA, sub. 94, p. 7)"

"[address] fiscal imbalances, so that where state or territory spending results in Commonwealth-level savings, these returns can be captured and reinvested … (Minderoo Foundation, Thrive by Five, sub. 145, p. 7)"

Ensuring cross-jurisdictional involvement does not inhibit progress

"Few processes in Australian governance are more prone to lengthy delay, degradation of goal and mission … than a project made conditional on a nine-government agreement … (Public Health Association of Australia, sub. 97, p. 6)"

"While it would be ideal for … intergovernmental governance structures to be established … alignment can occur once the … Framework is operational … (Cancer Council Australia, sub. 127, p. 8)"

"a Commonwealth, state and territory agreement as a precondition to the Framework, could result in unnecessary delay and jeopardise its implementation. (VicHealth, sub. 103, p. 14)"

A whole-of-government approach

Participants emphasised barriers created by siloed decision making across sectors.

> programs often fall between … silos, struggling to gain traction without a clear lead agency … Even when interdepartmental coordination mechanisms exist, they are often under-resourced or lack the authority to compel joint action. (CHA, qr. 65, p. 10)

Responses also acknowledged unfulfilled commitments to existing strategies involving prevention and promoted aligning new reform with past commitments.

> caution is needed to ensure [the proposed Board] does not create a new bureaucratic process and a barrier to innovation and long-term investment. … For simplification and alignment [proposed intergovernmental agreements] should form part of the National Health Reform Agreement … (Business Council of Australia, sub. 70, p. 7)

The National Preventive Health Strategy (2021–2030) was most referenced, however other strategies mentioned included the National Agreement on Closing the Gap, the National Plan to End Violence Against Women and Children and the National Mental Health and Suicide Prevention Agreement.

> The challenge is not a lack of frameworks, but the need for integration, coordination, and adequate investment. (Working with Women Alliance, Women With Disabilities Australia, Australian Multicultural Women's Alliance, and National Aboriginal and Torres Strait Islander Women's Alliance, sub. 126, p. 17)

At least twenty submissions further suggested linking our proposed reform to the Measuring What Matters Framework.

> a National Prevention Investment Framework provides a unique opportunity to work towards the outcomes described in Measuring What Matters. This ensures that prevention is valued not only for its efficiency gains, but for its capacity to promote improved wellbeing, social cohesion and fairer, healthier, and more resilient society. (VicHealth, sub. 103, p. 12)

Reflecting on barriers and inaction, most participants emphasised that strong and clearly defined governance will be crucial to enacting a successful whole-of-government approach to prevention.

> A challenge of this magnitude calls for more than piecemeal investment in prevention programs. It demands a coordinated, system-wide approach, one that rethinks how care is managed, funded, delivered, and experienced. (Australian Healthcare and Hospitals Association, sub. 26, p. 15)

Governance

Participants gave qualified support to the suggested governance structure and Prevention and Early Intervention Framework Advisory Board (PEIFAB), proposed as PFAB in draft recommendation 3.1. Submissions emphasised the need for diverse membership, transparency, and balancing independence and influence.

> A robust governance structure, led by PFAB, is essential to provide national coordination, and transparent oversight. (Cancer Council Australia, sub. 127, p. 10)

Similar to program prioritisation, participants had various opinions on PEIFAB's membership composition, but most encouraged diverse membership across sectors and skillsets.

> we were pleased to see the inclusion of cross-sectoral representation in the governance of the PFAB. This kind of genuine collaboration across agencies is a crucial step that has been a missing piece in other early intervention and prevention models. (NSW Council of Social Service & Australian Council of Social Service, sub. 169, p. 9)

Participants also conveyed the importance of voices reflecting cultural diversity in governance.

> Ensure the … Framework has mandated Aboriginal and Torres Strait Islander leadership on its advisory board and prioritises investment in community-led programs that strengthen the cultural and social determinants of health and wellbeing. (Gayaa Dhuwi (Proud Spirit) Australia, sub. 167, p. 4)

> The proposed Prevention Framework Advisory Board [should include] representation from multicultural health experts and consumer voices. (Australian Multicultural Health Collaborative, sub. 156, p. 5)

Many submissions also highlighted the value of transparency and institutional independence in PEIFAB processes.

> Independent review bodies … should oversee evaluation standards … publish transparent assessments, and guard against politically motivated defunding … (CHA, sub. 165, p. 47)

> An independent advisory board is crucial to retain impartiality, with a focus on the evidence and evaluation of programs on their own merit. (Lung Foundation Australia, sub. 120, p. 3)

> Any mechanism … should develop a strong feedback cycle, which should include transparency over what works and what doesn't. (Social Ventures Australia, sub. 163, p. 9)

Implementation by government

Some participants did not agree with the governance structure proposed in draft recommendation 3.1, suggesting that independence could unintentionally reduce influence. Participants presented alternatives, including housing PEIFAB in an existing organisation or supporting PEIFAB with additional governance elements.

> integration of operations with central agencies, particularly Treasury, remains necessary to effectively action recommendations. (Queensland Health, sub. 116, p. 10)

> Without direct levers to influence departmental behaviour or fiscal rules, a PFAB may struggle to shift the institutional inertia that so often stalls ambitious reforms. (CPD, sub. 244, p. 12)

Participants simultaneously recognised the complexity of implementing a solution to such a multifaceted problem as increasing investment in prevention and suggested a variety of approaches to implementation.

> a National Prevention Investment Framework should start with a small number of overall priorities … rather than trying to tackle a multitude of issues. (Diabetes Victoria, sub. 132, p. 2)

> We recommend that an interim framework is implemented as soon as practical with processes in place to iteratively improve the Framework over time. (DHE, sub. 61, p. 6)

Despite complexities and preconditions, most participants acknowledged the benefits of a more centralised process for prevention and supported the progress encouraged by the reform.

> We endorse the … Framework … as an important step to advancing meaningful reform in prevention funding. (HEG, sub. 243, p. 2)

> By embedding long-term investment structures, cross-portfolio recognition of value, and … evaluation pathways, the Framework can deliver measurable improvements for all Australians — reducing future costs and building healthier, more resilient communities. (Deafness Forum Australia, sub. 52, p. 1)

> There is an urgent need to significantly increase investment in prevention … a National Prevention Investment Framework would be an important step towards achieving this goal, improving the health and well-being of the community and reducing future demand … Investing in prevention is a fiscally responsible and sustainable approach. (Injury Matters, sub. 54, p. 1)

Emerging reform ideas

During the consultation process participants raised some reform ideas that were outside of the scope of this inquiry. Some of the ideas are outlined below.

Addressing ongoing care workforce challenges

Participants highlighted the workforce as a necessary enabler of the successful implementation of reforms and to the delivery of quality care. Concerns were expressed about capability, shortages, capacity and sustainability of the workforce and participants advocated for workforce reform.

> The most immediate threat to care quality, access, and system sustainability is the ongoing workforce shortage across the care economy. Competition between the aged care, health, and disability sectors for a limited pool of skilled workers is intensifying, placing all services under mounting strain. Without urgent, coordinated action, the capacity of the care system and its economic contribution risks serious decline. (Anglicare Sydney, sub. 138, p. 3)

> A stable, well-supported care workforce is foundational to effective prevention across the care economy. The current system, which relies heavily on insecure work, underinvestment in training, and fragmented service delivery, limits the capacity of workers to contribute to early intervention and long-term wellbeing of service users. (Australian Services Union, sub. 6, p. 3)

Workforce matters have been more broadly recognised in our inquiry report into *Building a skilled and adaptable workforce.*[3] Proposed reforms that enable better tertiary pathways and more flexible entry into occupations can benefit the care economy workforce.

Funding reform to support better outcomes and more efficient service delivery

Participants raised reform to system-wide funding, including moving towards value and outcomes-based funding models, in place of activity-based models.

> We must fundamentally rethink care payment models to improve care integration and increase productivity. … we recommend that the Government continue to focus on moving the healthcare system away from fee for service payment models towards value based payment models, where providers are financially rewarded for improving health outcomes. (Health Economics Collaboration, sub. 250, p. 10)

> Current funding models typically require resources to be directed almost exclusively to frontline service delivery … This constraint prevents … allocating resources to essential back-office functions … which are prerequisites for delivering services more effectively at scale. By underfunding these foundations, governments inadvertently perpetuate inefficiency, as providers are left without the tools, systems, and skills to innovate, adapt, and coordinate care. (Community Mental Health Australia, sub. 159, p. 6)

[3] Productivity Commission 2025, *Building a skilled and adaptable workforce*, Inquiry report no. 110, Canberra.

Recognising and supporting informal carers

Participants noted that Australia's informal carers are essential to the functioning and sustainability of the care system, yet their contributions are often overlooked.

> The contribution of Australia's 3 million informal carers was estimated to be $78 billion in annual replacement care costs in 2020 … Informal carers are clearly critical to the sustainability of our taxpayer-subsidised health and care systems. They also help people receiving care navigate the health and care systems and to receive care in their preferred settings for longer … But despite the invaluable contribution of informal carers, they are often overlooked including in conversations and policy debates about the care economy and productivity. (Carers Australia, sub. 143, p. 3)

They highlighted the impact caring responsibilities can have on workforce participation and productivity.

> Caring can also have an impact on carers (and these impacts can affect productivity with implications for the economy) … Caring can affect carers workforce participation, and the type of work they undertake … For example, carers may opt for lower-skilled and lower-paid jobs to fit into their caring schedules and/or to allow for more flexibility. When carers work at lower skill levels than they are capable of or could have performed if they had better health and wellbeing, this is a loss of human potential and productivity. (Carers Australia, sub. 143, p. 4)

A. Overview of engagement

Details of the consultation process and engagement methods for the inquiry are outlined below.

Consultation phases

Figure A.1 outlines the inquiry timeline and the key phases of consultation. In addition to the formal opportunities provided for participants to share their views, we also held meetings and roundtables with participants and maintained a '5 pillars' e-mail inbox open for correspondence throughout the inquiry.

Figure A.1 – Inquiry timeline and consultation phases

The responses received through Australia's Productivity Pitch are not summarised in this paper. A summary of what participants told us during this initial phase of consultation was published in February 2025. Read Australia's Productivity Pitch.

Engagement methods

We gathered written feedback from participants through three main methods.

Online questionnaires

We developed a targeted questionnaire to explore specific issues related to the three reform areas and to inform the direction of our interim report. The questionnaire included a mix of multiple-choice and open-ended questions, allowing participants to provide responses focused on particular aspects of the reforms. We also gave participants the option to submit additional documents to support their response. Read responses to the consultation questionnaire.

Pre-interim submissions

Some participants chose to provide submissions by email instead of completing the online questionnaire. These contributions were viewed alongside the questionnaire responses when drafting the interim report.

Post-interim submissions

Following the publication of the interim report on 13 August 2025, we sought further input on the reforms through information requests included in the interim report. Participants were asked to upload their submission via an online webform, with an option for uploading supporting documents.

Participants were also given the opportunity to make submissions via video or phone call.

Other consultation

In addition to written responses, we held 111 meetings with organisations and individuals, including government departments, industry and advocacy organisations, researchers, peak bodies, Aboriginal and Torres Strait Islander organisations, service providers and consumer groups. These meetings were held on a confidential basis to enable open discussion and are not summarised in this paper. The discussions informed our understanding of the issues and contributed to the development of our reform areas and the draft and final recommendations.

We also held three roundtables to explore regulatory reform and collaborative commissioning. These roundtables included peak bodies and aged care and disability service providers and local hospital and primary health networks. These roundtables were held following the release of the interim report.

Participation

We received 96 questionnaire responses, 33 pre-interim submissions, and 224 post-interim submissions from across the Australian community.