Australian Government
Productivity Commission

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Delivering quality care more efficiently

Inquiry report

No. 112 | 10 December 2025

Acknowledgment 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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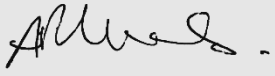
10 December 2025

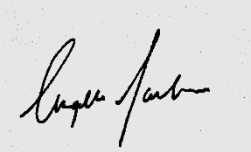
The Hon Dr Jim Chalmers MP
Treasurer
Parliament House
CANBERRA ACT 2600

Dear Treasurer

In accordance with section 11 of the *Productivity Commission Act 1998*, we have pleasure in submitting to you the PC's final report for the *Delivering quality care more efficiently* inquiry.

Yours sincerely





Alison Roberts
Commissioner

Angela Jackson
Commissioner

Terms of reference

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

Background

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

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

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

Scope of the inquiries

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

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

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

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

Process

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

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

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

The Hon Jim Chalmers MP
Treasurer

[Received 13 December 2024]

Disclosure of interests

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

Commissioner Dr Angela Jackson is Adjunct Associate Professor at the University of Tasmania and was previously a non-Executive Director of Melbourne Health.

Commissioner Dr Alison Roberts has no interests requiring disclosure.

Acknowledgments

The Commissioners acknowledge the valuable contribution of Commissioner Martin Stokie, who was part of the inquiry until the release of the interim report. They also express their appreciation to the staff who worked on the inquiry – Assistant Commissioner Catie Bradbear, who led the inquiry, and other team members including Archana Subramaniam, Billy Morton, Cordelia Buntsma, Cristy Alevizos, Daniel McDonald, Imogen Jameson, Luc Borrowman, Matt Forbes, Nicholas Sladden, Sasha Zegenhagen, Tim Griffin and Vanessa Boltman. Our thanks are also extended to Anna Heaney, Paul Gardner, Carmela Chivers, Matthew Muir, Yvette Goss and Tracey Horsfall for project support.

This report was prepared using the assistance of AI tools for the purposes of general research, note-taking, generating alternative text and support with coding for quantitative work. PC staff reviewed all AI-generated outputs for accuracy and quality.

Contents

Executive summary

Over the course of our lives, most of us will rely on a mix of formal and informal care and support, in ways that are shaped by personal needs, preferences and circumstances. We expect formal care to be safe, high quality and accessible. Care services offer more choice, quality and innovative delivery than they did a few decades ago. But as the population and its needs change, the care and support economy is coming under increasing pressure to deliver high-quality services at a sustainable cost. Without decisive action, future generations will face deeper health inequities and a care system increasingly unable to meet their needs.

Now is the time for governments to shape the future of the care economy. This report proposes reforms in three areas that strengthen connections across sectors and reduce siloed decision-making, improving care quality, making services more efficient and boosting productivity.

First, the Australian Government should pursue greater alignment in regulating quality and safety across care sectors. It should implement cross-sectoral provider registration and audits for aged care, veterans' care and National Disability Insurance Scheme services, with mutual recognition an interim step. Governments should also develop a national worker screening check. Getting these settings right will improve workers' mobility, better safeguard care users and reduce duplicative paperwork, saving workers and providers about $1.8 billion over 10 years once fully implemented, equivalent to over 21 million care hours. A single worker screening check will save care workers – 75% of whom are women – about $88 million a year. This includes the time value of approximately 419,000 hours a year that workers spend on duplicative paperwork.

Second, governments should embed collaborative commissioning – the practice of organisations working in partnership to plan, procure and evaluate services for their communities. Collaborative commissioning reduces fragmentation and can bring together the primary and acute parts of the health system. Governments should support collaboration between Local Hospital Networks and Primary Health Networks, in partnership with Aboriginal Community Controlled Health Organisations and other organisations. To achieve this collaboration, governments should strengthen governance arrangements, provide greater funding flexibility, enable access to data, build organisational capability and provide dedicated outcomes-based funding. These changes would enhance productivity and lower future costs – we estimate they can reduce potentially preventable hospitalisations by 5% and emergency department presentations by 4%, equivalent to $600 million per year.

Finally, Australia needs a new approach to investment in prevention and early intervention, through a National Prevention and Early Intervention Framework. Stopping problems from starting or getting worse can lead to better outcomes and reduce demand for more costly services down the track, helping to slow growth in government expenditure. Our framework would support a new investment approach, by recognising that benefits fall across sectors, governments, and over extended timeframes. A national independent advisory board would review and recommend programs, supported by new linked data and modelling infrastructure. An investment of $1.5 billion over five years would be expected to save governments $2.7 billion over ten years. When broader health, social and economic benefits are included, the net present value of total benefits would be about $5.4 billion. There is strong cross-sector support for embedding a more systematic approach into government decision-making and the costs of inaction are high. Better investment now can improve outcomes and alleviate increasing pressure on the care system and future budgets.

Recommendations

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

Recommendation 1.1
Align quality and safety regulation of workers across the care economy

The Australian Government, in collaboration with state and territory governments where required, should:

- establish a national worker screening check that combines current aged care, National Disability Insurance Scheme (NDIS), working with children and working with vulnerable people checks. The check should be supported by a national continuous checking capability that monitors clearance holders' criminal histories and communicates relevant offences to government agencies in real time
- design the proposed national worker registration scheme for personal care workers in aged care with sufficient flexibility to allow for any future expansion to the NDIS, the veterans' care sector or other care professions, should the Australian Government choose to introduce further registration requirements
- develop a single digital worker registration portal to allow workers registered under the proposed registration schemes in aged care and early childhood education and care to manage their registration details in one place. The portal should be designed with sufficient flexibility to enable it to support other worker registration schemes in the care economy if required.

Recommendation 1.2
Align quality and safety regulation of providers and services and assess the case for a single regulator

To begin aligning quality and safety regulation of providers and services across the care economy, the Australian Government, in collaboration with state and territory governments where relevant, should:

- develop a common suitability test for providers operating across the aged care, National Disability Insurance Scheme (NDIS), veterans' care and early childhood education and care (ECEC) sectors
- establish cross-sectoral registration and audits across the aged care, NDIS and veterans' care sectors, with mutual recognition of registration and audits as an interim step
- create a single digital portal for registration, approval and audits in aged care, NDIS and veterans' care, and for providers approved to administer the Child Care Subsidy in the ECEC sector
- establish a combined modular set of practice and quality standards across aged care and NDIS services
- align the regulation of behaviour support plans and restrictive practices for aged care and NDIS services
- identify opportunities and apply the principle of 'report once, use often' in data reporting across care sectors, initially focusing on the aged care, NDIS and veterans' care sectors.

The Australian Government should also assess the case for a single regulator across the aged care, NDIS and veterans' care sectors. In doing so, it should work closely with care users and providers and weigh the benefits, costs and risks of a single regulator.

Recommendation 1.3
Lead the implementation process and provide relevant agencies with direction

To enable greater alignment of regulation, including by implementing recommendations 1.1 and 1.2, the Australian Government should:

- appoint a Minister responsible for alignment of regulation across the care economy
- appoint lead agencies responsible for implementing each recommendation. Implementing agencies should publicly communicate timeframes, milestones and progress to promote transparency and accountability
- issue the National Disability Insurance Scheme Quality and Safeguards Commission and Aged Care Quality and Safety Commission with updated statements of expectations outlining that the two agencies should work together, and with other relevant government agencies, to align regulation and reduce duplication of regulation across care sectors.

Embed collaborative commissioning to increase the integration of care services

Recommendation 2.1
Establish stronger joint governance arrangements

Governments should agree to establish stronger joint governance arrangements that 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.

- LHNs and PHNs should be required to plan together to identify areas for collaboration, including joint needs assessments, agreed plans of work and joint monitoring and reporting of outcomes.
- LHNs and PHNs should work in partnership with ACCHOs and other organisations to inform planning and shared decision-making. Partnering with ACCHOs should be consistent with the principles set out in the National Agreement on Closing the Gap to ensure relevant needs are appropriately and respectfully assessed and decisions shared.
- Stronger requirements for formal joint committees to provide oversight and accountability for collaboration are needed.

The National Health Reform Agreement (NHRA) should be the main lever for moving beyond pilots and embedding these reforms, augmented by additional actions outside the agreement where necessary.

- If the 2026 addendum to the NHRA is not sufficiently prescriptive, the Australian Government should allocate some initial resourcing, potentially on a matched basis with state and territory governments, to progress the development of joint governance arrangements through bilateral agreements.

Recommendation 2.2
Enable more flexible funding

Governments should facilitate collaborative commissioning by making funding more flexible.

- The Australian Government should allow Primary Health Networks (PHNs) to have flexibility in how they achieve agreed outcomes.
- To enable collaboratively commissioned programs, state and territory governments should ensure that service agreements provide flexibility in the services and programs that Local Hospital Networks (LHNs) can fund.
- Both LHNs and PHNs should be allowed to pool funds that are being used to support collaboration.

Flexibility should be accompanied by appropriate guardrails to maintain accountability for achieving outcomes.

Recommendation 2.3
Provide dedicated funding based on outcomes

Stronger joint governance and increased funding flexibility are unlikely to be enough to embed collaborative commissioning across all regions of Australia; additional impetus is required, given the changes involved.

Governments should agree to outcomes-based dedicated funding arrangements that help Local Hospital Networks (LHNs) and Primary Health Networks (PHNs) to better collaborate, in partnership with Aboriginal Community Controlled Health Organisations and other organisations.

- Once a joint plan is submitted to the Department of Health, Disability and Ageing, the Australian, state and territory governments should provide LHNs and PHNs with sufficient dedicated funding to embed collaborative commissioning programs. The joint plan should clearly link agreed shared outcomes to enhanced productivity in the form of quality improvements or more services that lower future costs.
- Future funding should be based on the achievement of agreed shared outcomes – such as reduced potentially preventable hospitalisations – at the local level.

The Independent Health and Aged Care Pricing Authority should be immediately tasked with leading work to design the outcomes-based funding mechanism, to enable this approach to be implemented in the addendum to the National Health Reform Agreement expected to commence in 2031.

Recommendation 2.4
Take a strategic leadership role and ensure sufficient capability

Governments have a strategic leadership role in implementing reforms to embed collaborative commissioning. Australian, state and territory governments should ensure that all relevant departments, agencies and commissioning organisations have the required capability to support collaborative commissioning. Governments should:

- remove impediments to accessing data to facilitate more streamlined data sharing and linked datasets, and drive a focus on outcomes
- ensure there is appropriate resourcing and capability to monitor compliance and performance of LHNs and PHNs to support greater autonomy
- provide training and support programs to LHNs and PHNs in leadership, co-design, cultural safety practices and data capability.

Where necessary, bilateral agreements between the Australian and state and territory governments to progress joint governance arrangements (recommendation 2.1) should be harnessed to progress these actions.

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

Recommendation 3.1
Establish a National Prevention and Early Intervention Framework

The Australian Government should work with state and territory governments to establish a National Prevention and Early Intervention Framework. The framework would recognise prevention and early intervention as a strategic investment for governments and support them to invest in programs that improve outcomes and reduce demand for future acute and crisis care services.

Under the framework, a standardised review and recommendation process would assess governments' prevention and early intervention proposals and evaluate already funded programs by applying clear criteria regarding evidence, timescales, cross-portfolio benefits, equity effects and value for money.

The Australian Government Treasury should lead implementation of the framework, including by implementing recommendations 3.2 and 3.3. In partnership with state and territory governments, the Australian Government should progressively develop the capability, data assets and skills, as well as funding structures and processes, needed to embed investment in effective prevention and early intervention within the budget process.

Recommendation 3.2
Ensure better evaluation of prevention and early intervention

As part of the proposed National Prevention and Early Intervention Framework, the Australian Government should embed better evaluation of prevention and early intervention into government funding processes by building capability in assessing the long-term and cross-portfolio impacts of proposals. The Government should:

- establish an independent Prevention and Early Intervention Framework Advisory Board that reviews and recommends proposed programs for funding and validates estimates of cross-portfolio and long-term benefits. The board should publish its advice on policy proposals
- create a prevention and early intervention assessment team within Treasury to build government capability and support the standardised economic assessment of preventive programs
- develop, in partnership with state and territory governments, a whole-of-government actuarial microsimulation model to identify target cohorts across the population and project expected lifetime government service expenditure and key wellbeing outcomes. The Australian Government Actuary should develop the model guided by an intergovernmental working group. Australian, state and territory governments should have access to the model to assess the whole-of-community costs and benefits of prevention and early intervention policies.

Recommendation 3.3
Enable collaboration between Australian, state and territory governments

Recognising that the benefits and costs of effective prevention and early intervention often fall across different levels of government, the Australian Government should work with state and territory governments to address opportunities to fund programs through the proposed National Prevention and Early Intervention Framework (recommendation 3.1).

The Australian Government should lead work to establish a National Prevention and Early Intervention Fund to provide federal funding for state and territory-run programs requiring joint investment. The fund, which should be established within the Treasury portfolio, should involve a commitment of $1.5 billion over five years. States should co-fund programs based on their expected share of benefits, with these requirements outlined in federation funding agreement schedules.

Australian, state and territory governments should establish an intergovernmental agreement outlining the objectives of the framework, institutional, governance and data sharing arrangements, and roles and responsibilities of different parties.

In the longer term, the Australian Government should fund state and territory prevention and early intervention initiatives by modifying existing sector-specific federation funding agreements to allocate a portion of their funding to joint investments in prevention and early intervention on an ongoing basis. This approach would embed the framework into routine practice and expand its funding scale.

About this inquiry

Care is central to our lives and the economy

At its heart, care is a human interaction that supports wellbeing, dignity and an active life for all Australians (figure 1). Care and support services such as health care, early childhood education and care (ECEC), aged care, disability support and veterans' care[1] bring many benefits. They can improve the physical and mental health of care users, enabling them and their carers to participate more in the community and the economy. For example, access to ECEC and aged care services can boost the workforce participation of parents and care givers. A healthier population has higher labour force participation and productivity, and lower unemployment and absenteeism (PC 2017c, pp. 14–15). Care services also support vulnerable people, reducing disadvantage and improving health, social inclusion and general wellbeing.

Figure 1 – Many Australians use formal care services

Source: AIHW (2025b); NACCHO (2025, p. 13); NDIA (2025c); SCRGSP (2025b, 2025a).

The care economy is large and growing

Australia's care and support system is complex, involving multiple funding systems, quasi-markets and a mix of government, private and not-for-profit providers. It is one of the largest and fastest growing parts of the Australian economy, with more than 2.3 million people employed in care-related roles (ABS 2025e; PM&C 2023, p. 1). Women comprise 75% of the care and support workforce (Jobs and Skills Australia 2025).

Informal carers contribute substantially to people's care needs. In 2022, among those aged 65 years and over living in their home and needing assistance, 72% received care from family and friends and 58% received support from the formal care sector (ABS 2022). For some Aboriginal and Torres Strait Islander people, kin and community members undertake care responsibilities (Salmon et al. 2019, pp. 21–22). As in

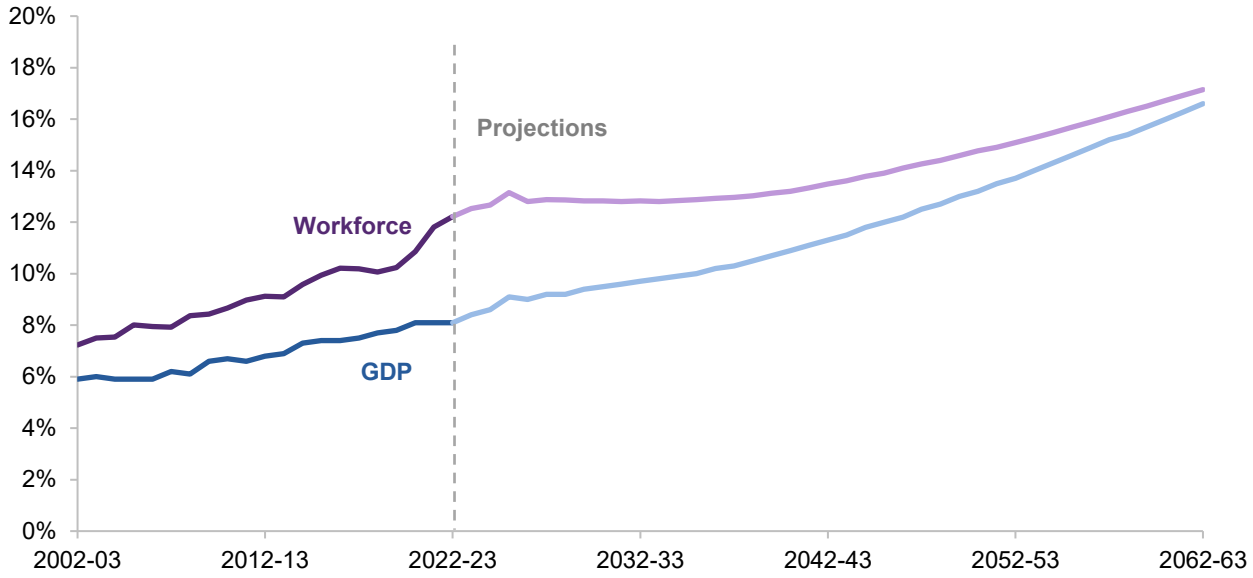
[1] Some reforms in this inquiry will also affect areas like education, housing, family services and justice services.

the formal care sector, women perform most of the unpaid care, accounting for two-thirds of primary care-givers (ABS 2022).

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

Figure 2 – The care economy will continue to grow

Care and support as a percentage of GDP and the workforce



Commonwealth of Australia (2023) data based on the Australian Bureau of Statistics' Australian and New Zealand Industrial Classification for the Health Care and Social Assistance Division, which uses Gross Value Added to represent total output. Nominal wage growth is projected to converge to 3.7% per year and possible technological advancements are not reflected in the estimates (Commonwealth of Australia 2023, pp. 231, 248).

Source: Productivity Commission estimates based on Commonwealth of Australia data.

This trend – not unique to Australia – is driven by several factors. The proportion of the population living with two or more chronic health conditions has increased (even after adjusting for population age structure changes over time) (AIHW 2024). An ageing population is exacerbating the rise in chronic illnesses and fuelling demand for health and aged care services (Commonwealth of Australia 2023). Further, as societies become wealthier, they tend to spend a larger share of income on services that enhance quality of life. At the same time, changing social norms have led to a shift from informal to formal care arrangements (Commonwealth of Australia 2023, p. 15). For example, female labour force participation has increased from about 45% in 1984 to about 63% in 2025 for those aged 15 years and over (ABS 2025d). This change has occurred alongside the expansion in ECEC services and the rollout of the National Disability Insurance Scheme.

The productivity challenge

Improving productivity in care sectors is challenging because of the fundamental human nature of care. Delivering more services per care giver is difficult without also constraining the personal interactions that are essential for high-quality care. Instead, much of the scope for improved care sector productivity lies in delivering better quality care.

Quality, however, is not captured in traditional approaches to measuring productivity. For example, multifactor productivity in the hospital sector grew on average by just 0.1% per year between 2008-09 and 2018-19 (ABS 2021) – below the average of 0.7% growth per year in the market sector (PC 2024a, p. 8). Yet the quality of some care and associated patient outcomes has improved significantly over time. For example, cancer treatments are far more effective today than in previous decades (PC 2024a, pp. 15–17).

When quality is considered, productivity growth can look quite different. For example, when adjusted for quality, productivity growth for a subset of the healthcare sector – accounting for about a third of healthcare spending – actually outpaced the broader economy, growing by about 3% per year between 2011-12 and 2017-18 (PC 2024a, p. 2).

Yet while improved productivity might be evident in the form of better outcomes, the care economy continues to grapple with rising costs. In other sectors, productivity gains can reduce the cost of producing goods or services, supporting higher wages. In care sectors, wages must rise to attract and retain workers, but these sectors do not experience the same reduction in costs from higher productivity. Higher wages and the labour-intensive nature of delivering care means that costs rise faster in care sectors than in other sectors, a phenomenon known as Baumol's cost disease. Simply put, Australians are getting better outcomes but not necessarily more care services per dollar spent.

New technologies offer scope to deliver large labour productivity gains while also improving care quality and lowering costs. AI scribes can reduce the time spent on reporting, while voice-activated AI platforms can provide personalised care reminders and notify caregivers when medication has been taken (Accenture, sub. 200, p. 15). Some residential aged care facilities in Australia have trialled the use of robots to help with tasks such as transporting linen and meals (Macalupu et al. 2024). Making the most of these technologies could free workers to focus more on high-value, face-to-face care. But harnessing these opportunities will require regulatory settings to support innovation while managing its risks.

The focus of this inquiry

Inquiry participants shared a wide range of ideas for improving productivity in the care economy (PC 2025c). This inquiry could not tackle all these suggestions. In some cases, other work is underway, and we are mindful that this inquiry comes at a time of significant change in some care sectors.

We have focused on reforms that would strengthen the connections between care sectors, mitigate the fragmented nature of the care economy, and break through the current siloed approach to government decision-making. Our care and support system must be able to respond to increasingly complex and overlapping needs that often span multiple sectors. To move toward this goal, we have identified three reform opportunities that target the micro, meso and macro levels of the system. Governments should:

- reform quality and safety regulation to support a more cohesive care economy (micro-level) (chapter 1)
- embed collaborative commissioning to increase the integration of care services (meso-level) (chapter 2)
- establish a national framework to support investment in prevention and early intervention (macro-level) (chapter 3).

These reforms have been shaped by the diverse perspectives of those who have engaged with this inquiry. They include care users, providers, workforce representatives, Aboriginal Community Controlled Organisations, industry groups, government agencies and academic and research organisations (PC 2025c). Across these groups we found broad in-principle support for our proposed reforms and have received valuable input that has helped us define practical pathways for implementation. What is needed now is government resolve. The reforms we outline are not a cure-all, but they are a significant step towards a care and support system that is more efficient and delivers better quality services for all.

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

Summary

- **Regulation is an essential part of the care economy, protecting against unsafe and poor-quality care and providing valuable indicators of service quality. However, fragmented and misaligned regulation across different care sectors creates unnecessary burden and costs for care users, workers, providers and government, reducing care quality and productivity. Removing unnecessary complexities and duplication can make it easier to protect the rights and safety of care users and improve efficiency.**

- **Similarities between the aged care, National Disability Insurance Scheme and veterans' care sectors provide scope to better align quality and safety regulation. But these sectors are not homogenous and regulation must continue to have flexibility to meet sector-specific needs. The Productivity Commission advocates for a system that consolidates regulation where there are commonalities while allowing for different approaches where needed.**

- **The Australian Government, in collaboration with state and territory governments where required, should build on efforts underway and pursue a suite of worker-, provider- and service-related regulatory reforms to align quality and safety regulation in the care economy and improve efficiency and outcomes for care users. We estimate that our recommendations will deliver $1.8 billion in savings in nominal terms across ten years, equivalent to over 21 million additional care hours.**
  - A national worker screening check will reduce the risk of harmful workers moving between care sectors and jurisdictions. It will save workers approximately $88 million per year, improve labour mobility, and will particularly benefit women, who comprise 75% of the care workforce.
  - Provider- and service-related reforms will streamline processes and reduce duplication for providers, to a total saving of $91 million per year. A simpler system that upholds quality and safety standards will also allow providers to focus more on delivering quality care.

- **Recent developments create an opportune moment to reinvigorate a reform agenda and align regulation in the care economy. To seize this opportunity and successfully implement our recommendations, the Australian Government should immediately establish the necessary policy infrastructure and begin implementing reforms.**

A more cohesive regulatory framework would improve the quality and efficiency of care

Quality and safety regulation is fragmented

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

However, current arrangements for quality and safety regulation are fragmented. Different legislative frameworks, standards or regulatory processes can apply across sectors, even when services are substantially similar. Significant sector-specific regulatory reforms introduced in recent years in response to royal commissions and reviews, while aiming to address serious harms and risks, have also often been developed in isolation or misaligned with other sectors.

Workers face increased paperwork and may miss employment opportunities

Workers face costs from a fragmented regulatory system in the form of duplicative screening checks. For example, National Disability Services (sub. 241, p. 20) stated that workers can face up to three separate screening processes depending on sector and jurisdiction. The Productivity Commission is not suggesting standards be lowered: effective worker screening is needed to protect the most vulnerable in our community. However, multiple substantially similar checks across sectors or jurisdictions impose unnecessary time and financial costs on care workers – most of whom are women – potentially causing them to delay or miss out on employment opportunities. When multiple agencies across sectors or jurisdictions conduct checks without effective information-sharing arrangements, unsafe workers can also slip through the cracks unnoticed, lowering protection for care users compared to a more cohesive system.

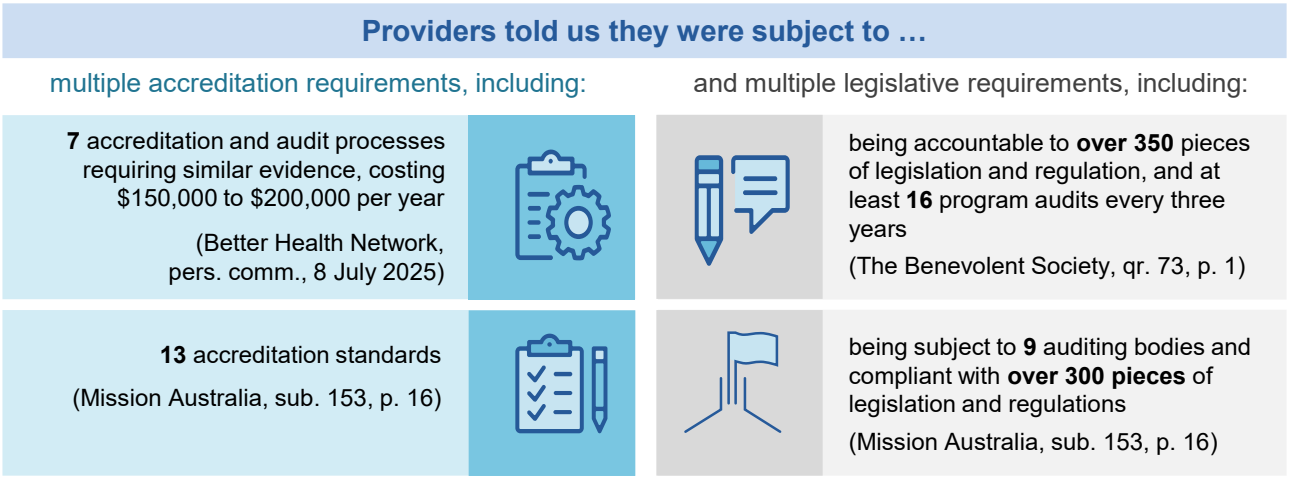
Providers face increased compliance costs

Providers told us that fragmented and misaligned regulations create significant costs (figure 1.1). For example, the Benevolent Society said:

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

The extent of compliance requirements has led Mission Australia (sub. 153, p. 16) to increase its dedicated risk and assurance team from seven to 10 full-time equivalent staff in the past three years, in addition to regularly outsourcing work to boost its internal auditing capacity. Echoing Mission Australia, other providers also said they often needed to employ specialised compliance personnel or direct frontline staff away from service delivery towards these administrative tasks, creating risks to quality and access (CHA, sub. 165, p. 17; HealthWISE, sub. 111, p. 1).

Figure 1.1 – Providers' experiences of regulatory burden



Governments must manage a more complex system

A disjointed regulatory system costs more to administer and makes it more difficult for governments to gain a bird's-eye view of the care economy. This is because governments must operate and maintain multiple regulatory regimes and agencies, each with their own systems and processes, with information about regulated entities spread across different government agencies. Higher costs to run the system mean that governments' care budgets cannot stretch as far (all else equal), and those who need care must wait longer, miss out or receive a lower-quality service.

Care users and carers ultimately pay the price

The impacts on providers, workers and governments described above all affect care users, and, consequently, their carers. For example, providers and workers may withdraw (or not expand) services across sectors, reducing care users' access to services. Time spent waiting for worker screening clearances can similarly delay users' access to care, especially where worker shortages already exist. Providers spending excessive time on regulatory compliance can divert attention away from providing care, reducing the quantity and potentially the quality of care that users receive. Finally, a fragmented system that allows unsafe actors to move unnoticed across sectors can result in care users unknowingly interacting with unsuitable workers and bearing the associated risks.

As well as these flow-on effects, care users and their carers may also experience confusion and difficulty when navigating a complex and fragmented regulatory system, affecting their ability to participate in decision-making about care arrangements. CHA said:

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

Margo Linn Barr said:

> 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. (qr. 35, p. 2)

And ACU said:

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

Care users are diverse, and fragmented regulation can adversely affect some cohorts of care users more severely or differently to others. For example, regulatory fragmentation can particularly pose barriers to Aboriginal and Torres Strait Islander people accessing culturally safe care (box 1.1).

Box 1.1 – Regulatory fragmentation affects Aboriginal and Torres Strait Islander people's access to culturally safe care

Within Aboriginal and Torres Strait Islander communities, caring for family members is deeply rooted in cultural practices and kinship systems. However, colonisation disrupted these traditional structures, creating challenges in Aboriginal and Torres Strait Islander people being able to access care in a manner that is culturally safe.

For Aboriginal and Torres Strait Islander people, cultural safety is an important component of safe, high-quality care. As Gayaa Dhuwi said:

> For Aboriginal and Torres Strait Islander Peoples, 'quality' and 'safety' are defined by the presence of cultural safety. (sub. 167, p. 3)

Care for Aboriginal and Torres Strait Islander people is most likely to be culturally safe when delivered by an Aboriginal or Torres Strait Islander worker or Aboriginal Community Controlled Organisation (ACCO). Aboriginal and Torres Strait Islander people also often prefer to access care from ACCOs (Kelly 2024, pp. 7, 53). However, misaligned systems of regulation can make it difficult for Aboriginal and Torres Strait Islander people to access care from ACCOs. For example, NACCHO said that:

> due to the poor alignment of regulatory systems between disability, aged care and primary healthcare, many [Aboriginal Community Controlled Health Organisations] are overburdened with maintaining regulatory requirements … This is a large barrier to ACCHOs delivering care services in addition to primary healthcare. (sub. 215, pp. 15–16)

The Interim First Nations Aged Care Commissioner also noted that existing quality and safety regulation, such as the financial and time costs of accreditation, creates barriers to ACCOs expanding into new care sectors (Kelly 2024, p. 55). Aligned regulation that makes it easier for ACCOs to operate across sectors would therefore be one step towards improving Aboriginal and Torres Strait Islander people's access to culturally safe, holistic care.

Regulation needs to be better aligned

There is significant scope for greater alignment in quality and safety regulation across the care economy to improve outcomes and reduce unnecessary administrative burden. While this is true across the care economy in general, it is particularly true for the aged care, National Disability Insurance Scheme (NDIS) and veterans' care sectors, and, to some extent, the early childhood education and care (ECEC) sector. For this reason, the PC's recommendations focus on these sectors.

We recognise that these sectors are not identical, and we are not advocating for full harmonisation, but rather greater consistency. As many inquiry participants noted, differences can exist across sectors in the characteristics, needs and preferences of care users, the skills required of workers and the contexts in which care is delivered.[2] Accordingly, tailored regulatory approaches can be necessary, and regulation must allow for these differences to ensure that care users receive the care they need.

Nevertheless, there remain substantial similarities between these sectors (box 1.2), creating scope for more aligned regulation. The aim should be to consolidate regulation where there are commonalities, while allowing for different approaches where needed. As the NDIS Commission said:

> Regulatory alignment can be achieved in a way that does not limit the ability for consumers to access services that meet their individual needs. (sub. 258, p. 7)

The goal is to *improve* outcomes for care users while reducing costs. However, at the very least, care quality must not be diminished in the pursuit of regulatory alignment.

Box 1.2 – Similarities across sectors form the basis for regulatory alignment

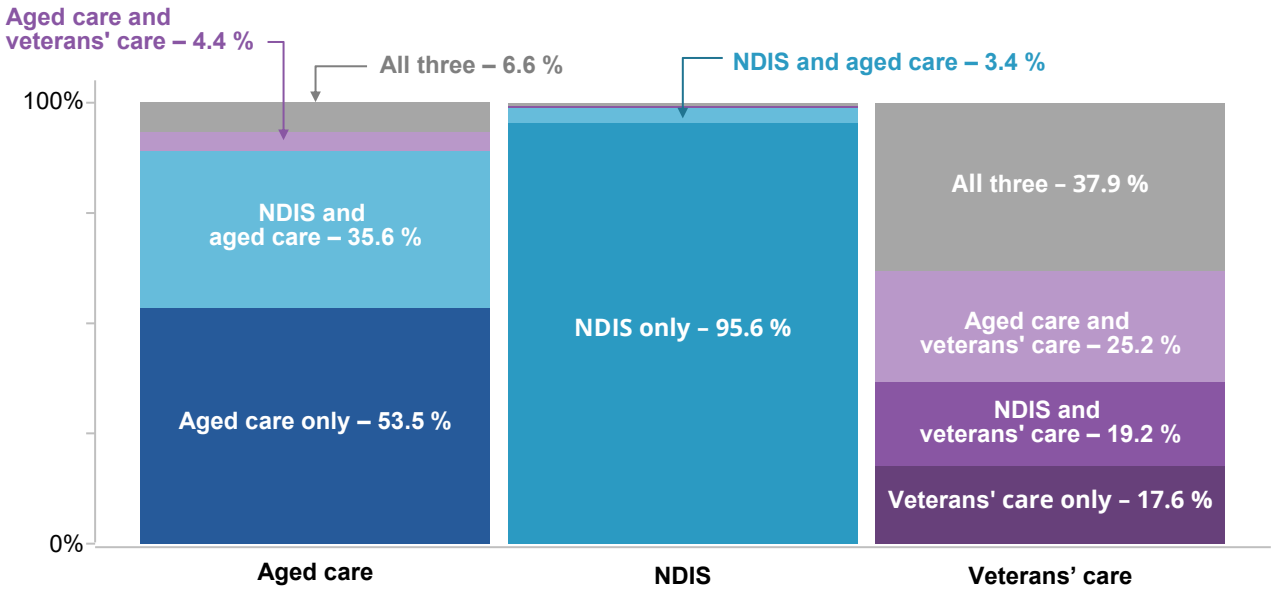
Similarities across the aged care, NDIS, veterans' care, and in some cases ECEC sectors include that:

- **the regulation of these sectors is rooted in the human rights of care users.** The need for care sector regulation to reflect human rights was a recurrent theme expressed by participants (for example, AHRC, sub. 235, p. 10; NDIS Commission, sub. 257, p. 10). While the aged care system does not have an equivalent basis in international law as the National Disability Insurance Scheme (Relationships Australia, sub. 65, p. 9), the need to uphold human rights in the delivery and regulation of services is nevertheless a unifying theme across sectors. For example, the new *Aged Care Act 2024* (Cth), which came into force on 1 November 2025, embeds a rights-based approach and includes a Statement of Rights that emphasises independence, choice and control (DoHAC 2025). The human rights implications of the new Aged Care Act include the right to an adequate standard of living and the right to the protection of a person's physical and mental integrity (Parliament of the Commonwealth of Australia nd, p. 9).
- **many providers operate across multiple sectors** (figure 1.2). For example, more than 42% of the approximately 2,132 aged care providers are also registered NDIS providers. Since these are generally the larger providers of aged care services, they constitute an even greater proportion of services delivered. Eighty-two per cent of veterans' care providers also offer services in aged care and/or the NDIS.
- **the types of services provided are similar.** The types of services provided across the aged care, NDIS and veterans' care sectors include assistance with daily living, personal care, social supports, allied health and therapy services and/or clinical care. While different care approaches can be required to tailor services to a person's needs, services across sectors are often similar at their core and require similar skills to deliver.

[2] For example, ACQSC (sub. 256, p. 3), Anglicare Sydney (sub. 138; p. 4), Australian Association of Gerontology (sub. 134, pp. 4–5), CAN (sub. 220, p. 16), Carers Australia (sub. 143, p. 9), Health Economics Collaboration (sub. 250, p. 6), NDIS Commission (sub. 258, p. 7), Volunteering Australia (sub. 171, p. 6).

Figure 1.2 – Many aged care, NDIS and veterans' care providers operate across sectors

Proportion of providers in each sector that operate across different sectors



Data for NDIS providers is for registered providers only. The large proportion of providers operating only in the NDIS reflects the relatively large number of registered providers in the scheme (approximately 22,000 compared to approximately 2100 in aged care and 370 in veterans' care). ECEC providers have been excluded. Of ECEC providers, 96.6% operate only in ECEC, 1.7% operate across at least ECEC and NDIS, 2.5% operate across at least ECEC and aged care and 0.2% operate across at least ECEC and veterans' care.

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

Achieving greater regulatory alignment

The PC envisages a system of quality and safety regulation that is aligned across all care sectors, levels of government and forms of regulation, consistent with principles of leading-practice regulation (PC 2020b). Achieving such a system will be a long-haul journey involving multiple interrelated pieces of work across different care sectors, aspects of regulation and parts of government.

To begin, the Australian Government should, in collaboration with state and territory governments where relevant, implement a series of actions focused on aligning worker, provider and service regulation in the aged care, NDIS and veterans' care sectors. It should also assess the case for a single regulator across these three sectors. This section discusses these proposals and their benefits.

Those who engaged with this inquiry widely supported greater alignment, although many also highlighted risks or other matters that would need to be addressed, such as ensuring sector-specific expertise was retained and balancing new reforms with those already underway (for example, Inclusion Australia, sub. 117, p. 1; UnitingCare Australia, sub. 123, p. 5). In supporting greater regulatory alignment, Uniting NSW.ACT said that:

> Overall, greater consistency across the care economy would benefit families, children and communities who often engage with multiple services. For Uniting, this would also help create a more joined-up experience across our service areas, while ensuring that workforce and governance expectations are clear, fair and consistent. Further, streamlining regulations and minimising administrative burdens on providers will lift productivity by allowing providers to redirect resourcing and capacity to improve outcomes for care recipients. This includes reducing

> the administrative burden on frontline staff and enabling more contact hours, investing in innovative ways of delivering care and facilitating more relational ways of working. (sub. 114, p. 6)

While our proposals focus on the aged care, NDIS and veterans' care sectors, and in some cases include the ECEC sector, many of the solutions we identify could be extended to other care sectors over time. We highlight these below where relevant.

Improving alignment in care worker regulation

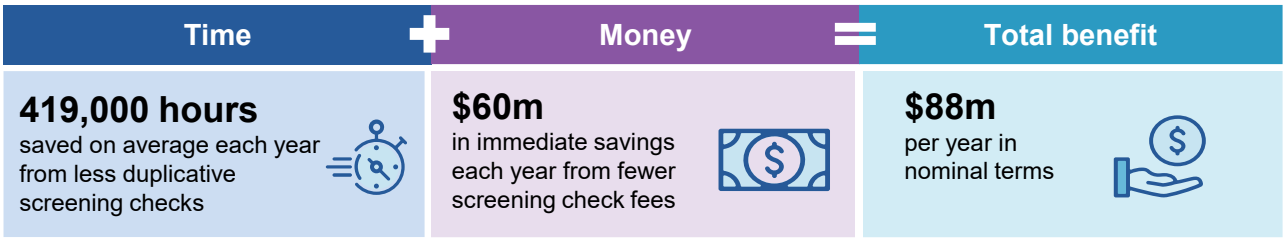
We propose three reforms to care worker regulation that build on work currently underway across governments. These are:

- establish a national worker screening clearance
- design the proposed aged care worker registration scheme in a way that would enable additional sectors to be included in future
- establish a single digital portal to support the worker registration systems in the aged care and ECEC sectors proposed by the Australian Government.

Inquiry participants overwhelmingly supported aligning care worker regulation to strengthen oversight, improve safety and facilitate workforce mobility.[3]

These reforms will lead to less time and money being spent completing duplicative worker-related checks and registration. A single worker screening check will save care workers about $88 million per year (figure 1.3, appendix B). This includes the time value of approximately 419,000 hours per year workers spend filling out duplicative paperwork, which could instead be spent working (paid or unpaid) or on leisure. Women would disproportionately benefit, given they comprise 75% of care workers.

Figure 1.3 – A national worker screening check will save care workers $88 million a year



The Department of Finance has also estimated the benefits of a national worker screening check (Commonwealth of Australia 2025). Differences between the PC's and Department of Finance's approaches to estimating the savings are explained in appendix B.

These numbers do not account for other benefits that would arise, such as improved safety for care users and the potential for care workers to start paid work in new care sectors and jurisdictions sooner. The latter is especially important given delays to starting work could lead to workers moving to other industries, which would exacerbate worker shortages and diminish the accessibility of care services.

> Anecdotal feedback from some care sector providers indicates it can take on average 28 days for a worker's clearance to be processed. During this period, many workers cannot afford to 'wait' and may seek employment in other industries with an immediate start. (EY Australia, sub. 147, p. 7)

[3] For example, ARIIA (sub. 122, p. 8), Ageing Australia (sub. 61, p. 7), ANZSGM (sub. 90, p. 3), ANMF (sub. 87, pp. 6–7), APA (sub. 112, p. 3), CHA (sub. 165, pp. 8–9), Life Care (sub. 77, p. 1), Inclusion Australia (sub. 117, p. 2), RAI (sub. 223, p. 9), Uniting NSW.ACT (sub. 114, p. 4).

These broader benefits, not captured in our estimates, will also have a greater impact on women, since they comprise the majority of the care workforce.

Establish a national worker screening clearance

The Australian, state and territory governments should establish a single national worker screening clearance that replaces existing clearances, such as NDIS worker screening checks, aged care worker screening checks (which have now been aligned with NDIS checks) and working with children/vulnerable people checks. The idea of a national worker screening check is not new – it was listed as a possible output on the reform agenda of the new National Competition Policy agreed by governments in November 2024 (Treasury 2024, p. 21) and was outlined as the second of two options in the September 2025 consultation paper on a national approach to worker screening in the care and support economy (Commonwealth of Australia 2025, pp. 6–7).

A national worker screening clearance would enable workers to apply for a clearance to work across all care sectors and jurisdictions through a single process, with checking automated to the greatest extent possible and supported by effective information sharing between regulators. Point-in-time checks to gain or renew clearances should be supported by a national continuous checking capability that monitors clearance holders' criminal histories in real time and notifies governments of any relevant offences. This will enable prompt action to be taken if a worker engages in inappropriate behaviour. Real-time continuous monitoring could build on work by the Australian Criminal Intelligence Commission to scope, design and pilot a national continuous checking capability for working with children checks and NDIS worker screening checks (ACIC 2025; Long 2025).

A single national clearance would remove the need for workers to undergo multiple screening processes, reducing administrative burden and application costs. It would also lead to more efficient checking processes and shorten wait times for clearances (both from more efficient checks and from avoiding the need to wait for multiple checks). Most importantly, by bringing together information from disparate databases across sectors and jurisdictions, it would enable regulators to respond more swiftly and effectively to workers who engage in inappropriate behaviour.

Design the aged care worker registration scheme with sufficient flexibility to encompass multiple care sectors

The Australian Government should ensure that the design of its proposed national registration scheme for personal care workers in the aged care sector, which is being implemented in response to recommendation 77 of the Royal Commission into Aged Care Quality and Safety, is flexible enough to be capable of expansion to NDIS and veterans' care personal care workers. This approach will avoid a potential proliferation of registration schemes and the need to bring disparate schemes into alignment in future, should the government mandate further requirements for the registration of personal care workers in the NDIS and veterans' care sectors.

One way to ensure sufficient flexibility would be to design requirements for aged care personal care workers in a way that distinguishes between core and specialised skills and qualifications. Doing so would pave the way for a cross-sectoral personal care worker registration system, where workers who meet the conditions of registration would be able to register once and work across the three sectors (within their registration category). Specifying entry requirements in this way may require a redesign and broadening of training programs, so that workers can provide person-centred care to people with a range of needs. The PC's

inquiry into *Building a skilled and adaptable workforce* discusses targeting qualification requirements to risk and adopting more flexible frameworks, including through the use of micro-credentials (PC 2025a).

As well as allowing for the potential expansion of worker registration to NDIS and veterans' care personal care workers, the Australian Government should incorporate design elements that would allow for registration to be expanded to other types of workers in these three care sectors. Designing the system in this way now would minimise costs to future affected workers and avoid barriers to future worker mobility.

While we envisage a system in which personal care and potentially other types of care workers are registered under a single scheme, we have not addressed the question of which types of workers should be required to be registered. Mandatory registration was an issue raised by many inquiry participants, particularly in relation to the NDIS (box 1.3).

Develop a single digital worker registration portal

Concurrent with the aged care worker registration scheme, the Australian Government, in collaboration with state and territory governments, is developing a national educator register in the ECEC sector, which is intended to be further developed into a national educator registration scheme (DoE 2025). While registration in aged care and ECEC should remain separate given the distinct focus of the sectors, the Australian Government should develop a single digital portal to support both registration systems. The portal should provide a single 'front door' for workers, allowing them to apply for, view, renew or update their registrations in one place and reduce the administrative complexity of managing multiple registrations. While initially created for the two registration schemes under development, it could be expanded to workers across the care economy in future, should additional registration schemes be introduced.

Box 1.3 – Participants repeatedly raised mandatory worker and provider registration

Worker and provider registration in the care economy is a topical issue, particularly in the NDIS where most workers and providers are not required to be registered. Many participants raised the issue of worker and provider registration in submissions, highlighting the quality and safety benefits of registration or noting that the PC's draft recommendations to streamline registration and audit processes (and their associated benefits) would apply only to those requiring or choosing to be registered. For example:

> Registration of services and individual support workers is particularly important for people with an intellectual disability, many of whom rely on workers they have not chosen themselves and may not know well. For people who do not have strong informal supports or family involvement, a worker register can provide a critical safeguard. (Inclusion Australia, sub. 117, p. 2)

> There remains an inherent and pervasive risk that providers who are subject to sanctions in one system can establish themselves as unregistered NDIS providers and therefore continue to deliver care services to vulnerable people. We echo our previous call for the implementation of mandatory NDIS registration as recommended by the NDIS Review which would address this loophole and ensure the effectiveness of cross sector registration and screening. (Uniting NSW.ACT, sub. 114, p. 5)

> The vast majority of providers are not required to demonstrate suitability to provide disability services, conduct worker screening, or comply with the NDIS Practice Standards. Such disparities undermine efforts to safeguard quality and safety across the entire sector. For

Box 1.3 – Participants repeatedly raised mandatory worker and provider registration

> reforms to have genuine impact, they must be extended to all organisations delivering NDIS supports — not just a select subset. (NDS, sub. 241, p. 7)

We acknowledge that mandatory worker and provider registration has the potential to enable better oversight of those operating across care sectors. We also note the recommendations of the NDIS Review and NDIS Provider and Worker Registration Taskforce and acknowledge the strong views (both ways) of many stakeholders on mandatory registration in the NDIS. In addition, the policy landscape is evolving, with proposed reforms to introduce mandatory registration for supported independent living, support coordination and platform providers in the NDIS (NDIS Quality and Safeguards Commission 2025b). Improved communication from the Australian Government on its intentions regarding mandatory universal worker and provider registration would provide clarity to NDIS providers and care users.

Recommendation 1.1
Align quality and safety regulation of workers across the care economy

The Australian Government, in collaboration with state and territory governments where required, should:

- establish a national worker screening check that combines current aged care, National Disability Insurance Scheme (NDIS), working with children and working with vulnerable people checks. The check should be supported by a national continuous checking capability that monitors clearance holders' criminal histories and communicates relevant offences to government agencies in real time
- design the proposed national worker registration scheme for personal care workers in aged care with sufficient flexibility to allow for any future expansion to the NDIS, the veterans' care sector or other care professions, should the Australian Government choose to introduce further registration requirements
- develop a single digital worker registration portal to allow workers registered under the proposed registration schemes in aged care and early childhood education and care to manage their registration details in one place. The portal should be designed with sufficient flexibility to enable it to support other worker registration schemes in the care economy if required.

Improving alignment in provider and service regulation

The Australian, state and territory governments should undertake a suite of provider- and service-related actions to better align quality and safety regulation. In addition, the Australian Government should assess the case for combining the aged care and NDIS regulators into a single entity that would also perform quality and safety regulatory functions in veterans' care services. These reforms aim to streamline processes and requirements for care providers without lowering standards, with flow-on benefits for care users. We estimate that aligned suitability, audits and registration processes, once fully implemented, will deliver time and cost savings to providers of $91 million per year (figure 1.4, appendix B).

Figure 1.4 – Aligned suitability, audit and registration processes will save providers $91 million per year

Importantly, these reforms are expected to improve outcomes for care users. We estimate our recommendations free up the equivalent of 1.1 million care hours each year,[4] which could be used to provide care to more people or invested in improving systems. Our proposed actions will also better safeguard care users against unscrupulous providers and support a more outcome-focused and joined-up care experience.

> Families we work with have consistently raised deep concerns that poor-quality and unsuitable providers are able to move unchecked between systems. These reforms are vital safeguards to prevent unfit workers and providers from exploiting regulatory gaps between systems. (ACD, sub. 78, p. 2)

> Reducing compliance burden through alignment of regulation across the care economy is one way to foster innovation, as it will lead to cost savings that can be reinvested by the provider into other areas. This could include data and digital solutions that promote increased efficiency, while delivering quality care. There are providers already leading in this space – for example, we are aware of providers using artificial intelligence to monitor for falls. (Ageing Australia, sub. 20, pp. 4–5)

Develop a common suitability test across aged care, NDIS, veterans' care and ECEC

The Australian Government should develop a common suitability test that providers complete once to operate across the aged care, NDIS, veterans' care and ECEC sectors. Currently, providers must demonstrate their suitability for each sector separately, although the assessments are often similar and can require the same types of supporting documentation. A single suitability test would remove this duplication.

Where suitability criteria relate to experience or competency in a specific sector, as they do in aged care, a modular approach could be employed. This would mean that providers expanding into a new sector would only need to satisfy any 'top-up' suitability criteria specific to that sector.

Over time, a common suitability assessment could be extended to other care sectors where suitability tests are undertaken, further reducing duplication.

A common suitability test could be facilitated by a single digital portal for provider registration, approvals and audits, given that suitability tests are generally conducted as part of registration or approval processes.

Create a single digital portal for provider registration, approval and audits

To reduce the number of contact points that cross-sector providers have with regulators and centralise information about their registrations, approvals and audits, a single provider portal should be developed for

[4] Equivalent care hours have been calculated by dividing the total annual savings once recommendations have been implemented by our assumed wage rate including overheads. See appendix B for more information.

providers in the aged care, NDIS and veterans' care sectors and those approved to administer the Child Care Subsidy in the ECEC sector. This portal would:

- store and present information about a provider's registrations, approvals and audits in the three sectors (as relevant), allowing providers to view and manage these details in one place
- allow providers to upload documents and other evidence related to registration, approvals and audits, which would be accessible to all relevant regulators as necessary, reducing the need for providers to submit the same or similar information multiple times to different regulators
- contain a provider's audit compliance history, which could be used to support mutual recognition of audits across the three sectors.

Appropriate security protocols must be in place to protect data stored on the portal. The consequences of any data breach to a centralised portal would be graver than for sector-specific portals, given the breadth of information it would contain. The Australian Government must therefore adopt sufficient protections to mitigate against this risk.

Over time, the portal could be further extended to other sectors or services where registration, approvals and/or audits are required.

A single portal could reduce the burden of compliance for providers operating across sectors even if regulatory requirements and processes differ, since many of the underlying standards or types of supporting evidence overlap. The portal would also be a stepping stone towards cross-sectoral provider registration and audits across the aged care, NDIS and disability sectors, as proposed below.

The single digital portal should allow providers to view and manage their registration and audits across sectors in a genuinely integrated way, rather than merely providing a common 'front door' beyond which digital systems remain siloed. Failing to truly integrate the functions of the portal would reduce its benefits and represent a wasted opportunity to streamline regulatory processes.

Establish cross-sectoral registration and audits for providers in aged care, NDIS and veterans' care, with mutual recognition as an interim step

Further to developing a common suitability test, the Australian Government should develop cross-sectoral provider registration and audit arrangements for the aged care, NDIS and veterans' care sectors. These arrangements would apply only to registered and audited providers.

Under a cross-sectoral registration system, providers across sectors would undergo a single process to be registered and would subsequently be able to work across the different sectors within their registration category (for example, household tasks). Registration categories would be the same across sectors – except potentially in a small number of cases where specialised categories are required – and have corresponding audit requirements. Such an arrangement would reduce the time and costs associated with multiple registration processes and could encourage providers to offer their services across multiple sectors, increasing the availability of services for care users.

We envisage a staged approach to the introduction of cross-sectoral registration and audits. First, the Australian Government should introduce mutual recognition of registration and audits. Mutual recognition would mean that registration in one sector would be enough to gain registration in the others, and compliance with one sector's standards would be accepted as evidence of compliance with equivalent or less onerous standards in the others.

To implement mutual recognition, the Australian Government would need to undertake an exercise to map and verify the equivalence of standards across aged care and the NDIS, building on work already

undertaken within the Department of Health, Disability and Ageing (ACQSC, pers. comm., 3 November 2025). This exercise should be informed by a practical understanding of how standards translate into the delivery of care across different settings, drawing on the input of care users, workers and providers. Standards should not be deemed equivalent unless they translate to equivalent forms of care in practice. The mapping process will also assist in identifying gaps or standards that are sector or context-specific and would require a supplementary module in the combined set of standards.

Once mutual recognition of registration and audits has been introduced, the Australian Government should develop the combined modular set of practice and quality standards, which will support a cross-sectoral system. The cross-sectoral registration and audit system should commence once the combined set of practice and quality standards has been established and all other necessary work to combine registration and audits under a single framework has been undertaken.

We note the Aged Care Quality and Safety Commission's (ACQSC) view that a substantial alignment of standards is a pre-requisite to the general adoption of mutual recognition arrangements (sub. 256, pp. 8–9). We acknowledge that, in recommending mutual recognition occurs first, there may be fewer instances of equivalence than if standards were first aligned. Nevertheless, mutual recognition would allow some benefits to be realised sooner. The current NDIS practice standards review also offers an opportunity to bring standards into closer alignment prior to developing the combined set of practice and quality standards.

Several practical issues will need to be worked through in implementing a cross-sectoral provider registration and audit system. For example, differences in how 'providers' are defined in the aged care and NDIS regulatory frameworks may need to be reconciled.[5] Similarly, cross-sectoral arrangements may need to account for differences in who conducts audits across sectors – at present, audits in the aged care sector are conducted by the ACQSC, whereas in the NDIS they are undertaken by private Approved Quality Auditors. The government agency responsible for leading this reform – likely the Department of Health, Disability and Ageing – should address such issues in the design and implementation phase of the reforms.

Establish a combined set of modular practice and quality standards across aged care and the NDIS

To support cross-sectoral audits, the Australian Government should combine the strengthened aged care quality standards and NDIS practice standards into a single set of modular quality and practice standards. The combined standards would apply to registered aged care and NDIS providers, as well as veterans' care providers that are required to adhere to aged care standards through their service agreements.

The combined standards should have core modules that apply to most or all providers, along with supplementary modules that apply depending on the type of services delivered. The unified standards should establish common standards for similar types of services across sectors – that is, audit modules should not be sector-specific unless there are clear differences in risks that justify this. Standards should be developed to uphold and not dilute quality and be appropriate for all care settings.

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

Assess the case for a single regulator and implement resulting actions

The Australian Government should assess the case for a single quality and safety regulator that combines the ACQSC, the NDIS Quality and Safeguards Commission (NDIS Commission) and the regulatory functions of the Department of Veterans' Affairs into a single statutory agency.

A single regulator would streamline oversight across sectors, replace fragmented responsibilities with a more coordinated, consistent and efficient approach, reduce confusion for providers and care users about roles and responsibilities (for example, who to make complaints to) and eliminate duplication in functions such as compliance monitoring and enforcement. It would be a natural extension of a single set of standards, and common registration and audit requirements. Further, a single regulator would be well placed to report on quality and safety across the care sector and to support benchmarking and innovation. This would lift the overall standard of care in these sectors and improve trust and confidence in the system.

However, moving to a single regulator also brings costs and risks. For example, many participants highlighted the risk of a single regulator losing sector-specific expertise or overlooking sector-specific needs and nuances.[6] Some also pointed to the high costs of transitioning to a single regulator or a lack of readiness in some sectors for such an arrangement.[7] In general, participants were mixed in their support for a single regulator.

In assessing the case for a single regulator, the benefits should be weighed against the costs to determine whether it is in the interests of care users and the community. The Australian Government should explore different models that could be applied to manage costs and risks, and work in close collaboration with care users and providers, consulting in a way that enables all to participate. If, after assessing the case, the Australian Government decides to pursue a single regulator, it should undertake the necessary preparations for its commencement, including any further consultation and legislative change.

Align the regulation of behaviour support plans and restrictive practices and work towards the reduction and elimination of restrictive practices

The Australian Government should, in collaboration with state and territory governments, take actions to align the regulation of behaviour support plans and restrictive practices in aged care and NDIS services.[8] Regulation in these areas is highly complex, with implications that go beyond aged care and the NDIS. Nevertheless, better alignment has the potential to vastly improve outcomes and experiences for the most vulnerable care users across aged care, the NDIS and beyond. For example, minimising inconsistency can empower care users to assert their rights, including through making complaints (ACQSC, sub. 256, p. 12). Similarly, it can avert confusion on the part of workers about their roles and responsibilities – which can differ under current frameworks – leading to more timely, appropriate, consistent and effective care (Ageing Australia, sub. 20, pp. 2–3; ANMF, sub. 87, p. 12; KPMG Australia, sub. 115, p. 2). Many inquiry participants supported greater alignment of the regulation of behaviour support plans and restrictive practices.[9]

[6] A20 Quality and Safeguarding Peer Network (sub. 158, p. 3), ACD (sub. 78, p. 3), Australian Association of Gerontology (sub. 134, p. 6), AMA, sub. 94, p. 2), ANMF (sub. 87, p. 10), Life Care (sub. 77, p. 1), MFC (sub. 73, p. 4), Mission Australia (sub. 153, p. 17), Uniting NSW.ACT (sub. 114, p. 5), UnitingCare Australia (sub. 123, p. 5).

[7] CHA (sub. 165, p. 17), EY Australia (sub. 147, p. 7), MFC (sub. 73, p. 4), Mission Australia (sub. 153, p. 17).

[8] Restrictive practices are practices or interventions that limit a person's human rights or freedom of movement. Types of restrictive practices include: seclusion, where a person is placed in a room alone and is not allowed to leave; chemical restraint, where a person is given medicine to stop or reduce a behaviour, and mechanical restraint, where a device or equipment is used to stop or reduce a behaviour (DoHAC 2022; NDIS Quality and Safeguards Commission 2025a).

[9] For example, AMA (sub. 94, p. 3), ANMF (sub. 87, p. 12), BSL (sub. 180, pp. 1–2), Inclusion Australia (sub. 117, p. 3), Uniting NSW.ACT (sub. 114, p. 4).

At the same time as seeking to align regulation, governments should also look to reduce and eliminate the use of restrictive practices over time, consistent with the United Nations *Convention on the Rights of Persons with Disabilities* and the National Framework for Eliminating the Use of Restrictive Practices in the Disability Service Sector. Previous work could provide guidance in this regard (for example, The University of Melbourne et al. 2023). Reducing and eliminating the use of restrictive practices was strongly supported by inquiry participants.[10]

Specific actions governments could take to align the regulation of behaviour support plans and restrictive practices (while aiming to reduce and eliminate the use of restrictive practices over time) could include:

- aligning definitions of restrictive practices across care sectors and states and territories
- better aligning processes for the authorisation of restrictive practices across states and territories
- streamlining reporting requirements on the use of restrictive practices across different sectors and levels of government.

Identify opportunities and apply the principle of 'report once, use often' in data reporting across sectors

In collaboration with state and territory governments where relevant, the Australian Government should identify and implement actions that apply the principle of 'report once, use often' for data reporting, focusing on the aged care, NDIS and veterans' care sectors in the first instance. This would be consistent with the 'tell us once' principle that the PC, in its inquiry into *Creating a more dynamic and resilient economy*, has recommended be part of a whole-of-government statement on regulation (PC 2025b).

The aim of these actions should be to reduce duplicative reporting obligations on providers, as well as to publish service performance information that facilitates care user choice and service improvement. In keeping with our other proposals, actions to reduce the burden of reporting should initially focus on the aged care, NDIS and veterans' care sectors, with governments looking further afield over time.

Governments should explore developing a standardised quality, safety and/or performance data framework as part of this work. Any such framework should, in addition to having published indicators at an aggregate level to inform care users about safety, quality and performance, enable providers to understand their performance relative to other similar providers.

Additional potential actions could include:

- streamlining reporting requirements on the use of restrictive practices, as discussed above
- streamlining incident reporting requirements
- streamlining reporting requirements relating to key personnel or responsible persons – although, to the extent that these reporting obligations arise as a result of registration conditions, the single digital portal for registration and audits proposed above may partially address this issue.

[10] For example, AHRC (sub. 235, p. 11), Inclusion Australia (sub. 117, p. 3), Uniting NSW.ACT (sub. 114, p. 4), WwWA, WWDA, AMWA and NATISWA (sub. 126, pp. 12–13), WWDA (sub. 188, pp. 8–9).

Recommendation 1.2
Align quality and safety regulation of providers and services and assess the case for a single regulator

To begin aligning quality and safety regulation of providers and services across the care economy, the Australian Government, in collaboration with state and territory governments where relevant, should:

- develop a common suitability test for providers operating across the aged care, National Disability Insurance Scheme (NDIS), veterans' care and early childhood education and care (ECEC) sectors
- establish cross-sectoral registration and audits across the aged care, NDIS and veterans' care sectors, with mutual recognition of registration and audits as an interim step
- create a single digital portal for registration, approval and audits in aged care, NDIS and veterans' care, and for providers approved to administer the Child Care Subsidy in the ECEC sector
- establish a combined modular set of practice and quality standards across aged care and NDIS services
- align the regulation of behaviour support plans and restrictive practices for aged care and NDIS services
- identify opportunities and apply the principle of 'report once, use often' in data reporting across care sectors, initially focusing on the aged care, NDIS and veterans' care sectors.

The Australian Government should also assess the case for a single regulator across the aged care, NDIS and veterans' care sectors. In doing so, it should work closely with care users and providers and weigh the benefits, costs and risks of a single regulator.

Now is an opportune moment to restart alignment efforts

The need for greater regulatory alignment in the care economy has long been recognised. Several efforts have been made to align regulation in recent years (box 1.4) but have largely lost momentum. However, recent developments present a renewed opportunity to pursue and persist with reform. For example:

- in May 2025, the Australian Government Minister for Health and Ageing was appointed Minister for Disability and the NDIS, while Australian Government disability policy was moved into the newly created Department of Health, Disability and Ageing (Butler 2025; PM&C 2025). These changes reduce fragmentation of responsibility for the care economy across portfolios and create clearer responsibility for aligning aged care and NDIS regulation
- all relevant reviews and royal commissions over the past few years have now reported, giving the Australian Government an opportunity to take stock and identify opportunities for more consistent regulation across sectors
- the introduction of the *Aged Care Act 2024* involved aligning some regulatory actions (for example, provider registration is now more aligned with NDIS requirements than previously), demonstrating new ways of working across care sectors
- worker registration and worker screening policy reforms in the care economy are underway, providing opportunities for these to be designed and implemented in a way that supports regulatory alignment.[11]

[11] In August 2025, the Standing Council of Attorneys-General agreed to deliver a national approach to working with children checks (Rowland 2025) and education ministers agreed to a package of child safety reforms, including a national educator register (DoE 2025). In September 2025, the Treasury and Department of Finance released a consultation paper exploring models for national worker screening (Commonwealth of Australia 2025) and the Australian Government has committed to continue work on a national screening process for workers in the care and support sectors (Chalmers 2025).

To take advantage of the opportunity for renewed action on regulatory alignment and to drive reform, the Australian Government should take the following actions relating to policy governance.

Box 1.4 – Previous efforts have been made to align regulation in the care economy

In 2021, a regulatory alignment taskforce was established within the Department of Health (now the Department of Health, Disability and Ageing). The 2021–22 Budget provided $12.3 million over two years to increase information sharing between regulators, align auditing arrangements and compliance and enforcement powers, review the NDIS Quality and Safeguards Framework and consult with the sector about options for further reform to align regulation and safeguards (Commonwealth of Australia 2021, p. 178). The taskforce published several background and consultation papers on regulatory alignment, consulted with stakeholders and summarised their views (DoH 2021b, 2021a, 2022) and developed an aged care code of conduct.

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

Appoint a lead Minister to drive alignment

A key factor in the success of any regulatory alignment agenda will be sufficient leadership and direction from a relevant Minister to drive action. To create the focus and impetus needed to successfully implement the reform program, the Australian Government should appoint a Minister with responsibility for regulatory alignment across the care economy.

The appointed Minister should set a clear vision for regulatory alignment in the care economy and regularly and consistently communicate this vision to the care system and public. This vision could form part of the Australian Government's overall statement on regulation, as recommended in the PC's inquiry into *Creating a more dynamic and resilient economy* (PC 2025b).

Given the cross-portfolio nature of the care economy, the Minister will need to work with other relevant Ministers and bring together multiple agencies for collaboration. While individual Ministers and agencies will be responsible for progressing specific regulatory alignment activities within their remit, the lead Minister would be accountable for the progress and implementation of the regulatory alignment agenda as a whole.

Appoint lead agencies to steward reforms

To progress implementation of the regulatory alignment agenda, each action should be allocated to a lead agency. As noted above, the regulatory alignment agenda will span multiple portfolios and agencies. Individual actions may also require collaboration across agencies and/or governments. Nevertheless, having a lead agency responsible for each reform will ensure clear accountability for driving progress.

Lead agencies should have the expertise to implement their assigned actions and could use existing care economy working groups and forums where relevant. Existing state and territory forums could also be

leveraged to deliver actions that require intergovernmental cooperation. To ensure accountability and transparency, lead agencies should publicly issue timelines and regular progress updates.

Issue statements of expectations to embed collaboration between regulators

While government agencies are responsible for implementing government policy, the ACQSC and NDIS Commission will be responsible for overseeing adherence to any newly aligned regulatory frameworks. Their role is therefore critical to the success of the proposed reforms. To reflect this, the Minister for Health, Disability and Ageing should issue the ACQSC and NDIS Commission with updated statements of expectations (SoEs) that aim to embed collaboration between the regulators and further break down care sector silos.

Updated SoEs for the ACQSC and NDIS Commission should include the expectation these regulators work together and with relevant departments toward greater regulatory alignment and to reduce regulatory duplication and fragmentation between the aged care and NDIS sectors. This is consistent with the Australian Government's recently set objective for Commonwealth regulators to better balance risk mitigation with efficiency, growth and dynamism, and its agreement for new SoEs to reflect this objective (Finance 2025a). The regulators should outline their responses in statements of intent. Further discussion on the role of SoEs in strengthening regulatory practice can be found in the PC's inquiry into *Creating a more dynamic and resilient economy* (PC 2025b).

Recommendation 1.3
Lead the implementation process and provide relevant agencies with direction

To enable greater alignment of regulation, including by implementing recommendations 1.1 and 1.2, the Australian Government should:

- appoint a Minister responsible for alignment of regulation across the care economy
- appoint lead agencies responsible for implementing each recommendation. Implementing agencies should publicly communicate timeframes, milestones and progress to promote transparency and accountability
- issue the National Disability Insurance Scheme Quality and Safeguards Commission and Aged Care Quality and Safety Commission with updated statements of expectations outlining that the two agencies should work together, and with other relevant government agencies, to align regulation and reduce duplication of regulation across care sectors.

Sequencing implementation of reforms

We propose that governments implement our recommendations over an eight-year timeframe, with the majority completed by 2030 (figure 1.5). Reforms relating to digital solutions could be implemented sooner than envisaged, given the fast pace at which digital capabilities and innovations are advancing.

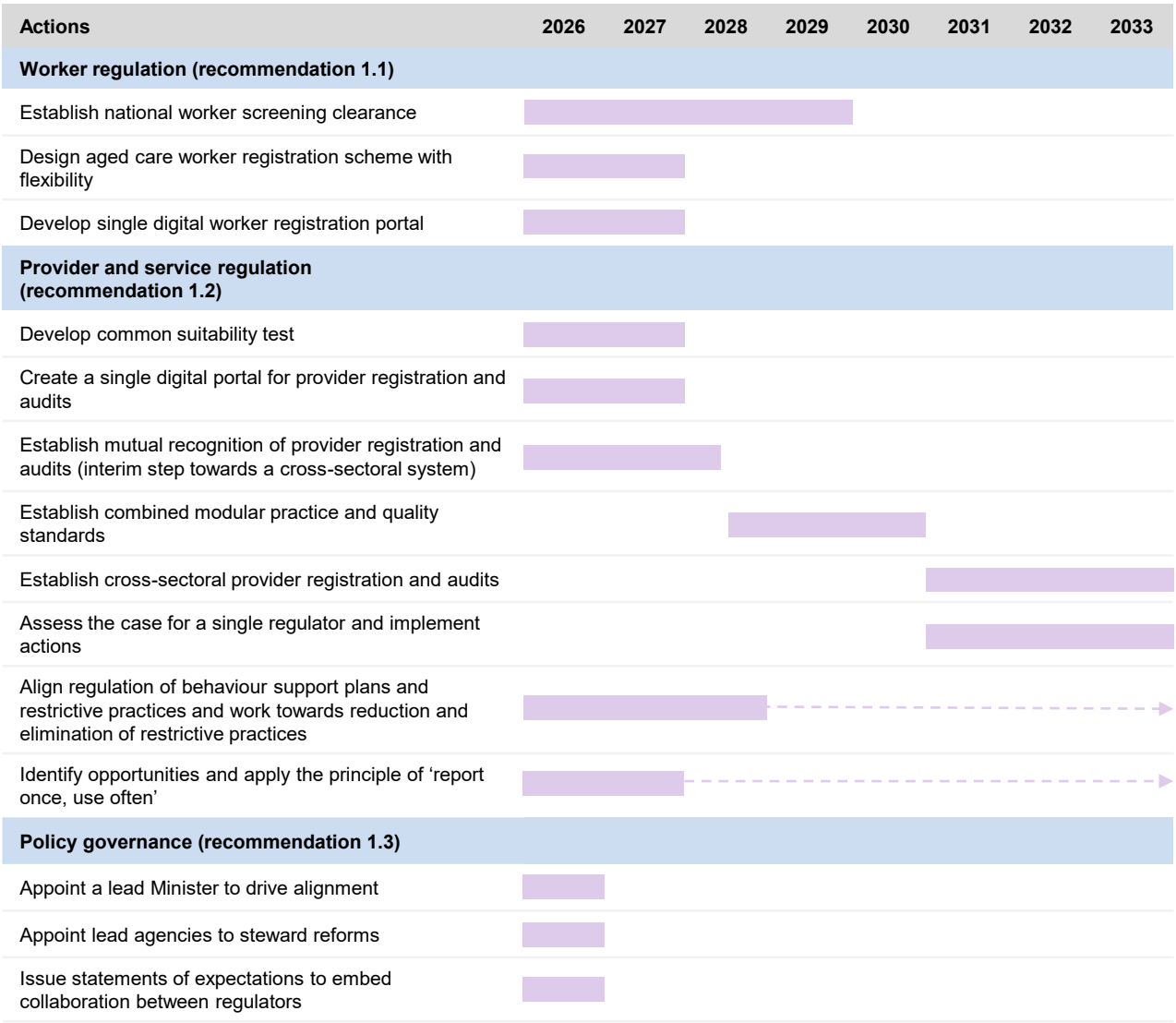
The proposed timeframes reflect the need to be ambitious, while recognising the significant changes to regulation that have occurred in the care economy in recent years, particularly in aged care and disability support. Inquiry participants, while generally supportive of the recommendations, noted that providers are experiencing reform fatigue and will have different levels of capacity for further change.[12] Implementation of

[12] Ageing Australia (sub. 161, p. 10), Australian Association of Gerontology (sub. 143, p. 3), CE CRC (sub. 232, p. 1), Silverchain (sub. 204, pp. 7–8).

our recommendations should also continue alongside, and not interrupt or delay, the progress of other policy initiatives in the care economy (Anonymous, sub. 210, pp. 1, 6; BSL, sub. 180, p. 2).

Implementation of worker-related recommendations should begin immediately, with the national worker screening clearance established within four years and the remaining worker-related actions completed within two years. The four-year timeframe for the worker screening clearance allows for the complexity of implementing the clearance across four different care sectors, and the need for the Australian Government to collaborate with state and territory governments.

Figure 1.5 – An implementation plan towards greater regulatory alignment



Provider- and service-related recommendations should be implemented in a more sequential manner – starting immediately with the common suitability test, the single digital registration and audit portal and mutual recognition of registration and audits. Work to develop a combined set of practice and quality standards should then begin once mutual recognition is in place, with cross-sectoral provider registration and audits implemented once the standards are developed. Concurrently, the Australian Government should also assess the case for a single regulator and implement any resulting actions. A staged approach reflects the interrelated nature of these reforms, and, to some extent, their natural sequencing (although, as noted above, the ACQSC (sub. 256, pp. 8–9) proposed a different sequence). In addition, it allows government agencies to 'learn by doing' as they embark on the journey of reform.

The reforms on aligning the regulation of behaviour support plans and restrictive practices, and applying 'report once, use often' in data reporting, should commence immediately and have an active work program over the next three and two years respectively, although some actions may require longer to complete. Recommendation 1.3 should also be enacted immediately and be completed within one year, since it sets the preconditions for successfully delivering all other recommendations.

Implementation should be guided by leading-practice principles

In implementing the PC's recommendations, governments will need to design the details of the specific measures proposed. This design process must adhere to leading-practice regulatory design principles, which include that the objectives of regulation are clearly defined, consultation during regulation-making is sufficient and regulation is not overly complex or excessively prescriptive (PC 2020b, p. 99). In the context of the care economy, these principles mean that reforms must be co-designed with care users, governments must partner with Aboriginal and Torres Strait Islander people and regulation must take a broad view of the care economy (table 1.1).

Ensuring alignment of regulation going forward

This chapter has identified and provided implementation advice on the specific set of actions set out in our recommendations. Beyond these actions, governments also have a broader role in pursuing regulatory alignment in the care economy now and into the future and should make decisions with the goal of alignment in mind. The PC provides the following advice in this respect.

Governments must not further entrench silos

A first step is for governments to avoid introducing measures that create or further entrench silos between care sectors. Two examples are particularly pertinent in the current policy landscape.

First, as outlined above, the Australian Government is currently grappling with worker registration issues in multiple care sectors. Any registration requirements that are introduced or contemplated must therefore consider the potential for further requirements to be introduced in the future – new requirements that are not designed well could result in duplication, unnecessary regulatory burdens or restrictions on worker mobility. Designing the proposed aged care registration scheme flexibly (as proposed above) is one way to avoid these consequences. However, the Australian Government should also design any other worker registration schemes it plans to introduce in a way that preserves the cohesiveness of worker registration schemes across the care economy.

Table 1.1 – Leading-practice regulatory design principles for the care economy

Principle	Rationale and description
Co-design reforms with care users	Care users should be involved in decisions that affect their lives. The design and implementation of reform to align regulation should be informed by input from care users to support rights-based approaches and shared decision-making. Incorporating lived experience requires inclusive engagement, ensuring diversity across and within care sectors. Intersectionality must also be considered – for example, the PC heard that multicultural women's networks are often sidelined in consultation (WwWA, WWDA, AMWA and NATSIWA, sub. 126, p. 12).
Partner with Aboriginal and Torres Strait Islander people	Consistent with the National Agreement on Closing the Gap, governments should partner with Aboriginal and Torres Strait Islander people in designing and implementing the proposed reforms. This will ensure the benefits for Aboriginal and Torres Strait Islander people are realised in practice. For example, reducing the burden of regulation for providers (recommendation 1.2) should lower barriers to entry for ACCOs wishing to expand into new care sectors. A national worker screening check should also enable care workers to more easily move between care sectors, increasing the supply of culturally safe workers. Partnering will also prevent any unintended adverse consequences for Aboriginal and Torres Strait Islander people from the reforms. For example, Australia's Interim First Nations Aged Care Commissioner reported that Aboriginal and Torres Strait Islander people and communities raised concern that a nationally consistent worker screening check could remove providers' discretion to employ workers with low-grade criminal convictions (Kelly 2024, p. 53). Given the overrepresentation of Aboriginal and Torres Strait Islander people in the criminal justice system, this may have a disproportionate effect on Aboriginal and Torres Strait Islander care workers and providers. In partnering with Aboriginal and Torres Strait Islander people, engagement must be culturally safe and conducted in a manner consistent with governments' commitments under the National Agreement on Closing the Gap.
Take a broad perspective of the care economy	As noted throughout this chapter, the care economy is highly interconnected, despite often being funded or regulated as distinct sectors. While this inquiry has focused on aged care, the NDIS and veterans' care, and in some instances, ECEC, governments should not forget that these sectors are part of a broader care economy spanning sectors such as health, mental health and family services, and must design reforms accordingly. Inquiry participants suggested there may be future opportunities to continue regulatory alignment in other parts of the care economy, including healthcare (Carers NSW, sub. 121, p. 1) and mental health services (APA, sub. 112, p. 3; NDS, sub. 241, p. 8; QAMH, sub. 172, p. 5).

Second, governments should ensure they adopt consistent approaches to the regulation of artificial intelligence (AI) across the care economy, which would support its uptake. Consistent approaches do not necessarily mean a bespoke regulatory framework – for example, regulators could instead adopt consistent regulatory practices under their respective legislation. Given that AI is a relatively new technology, governments should take the opportunity to ensure a cohesive approach to regulation from the outset, rather than allowing sector-specific approaches to develop, which create complexity and inconsistency. This consistency should also extend to the frameworks governing how regulators themselves may use AI in performing their regulatory functions.

In keeping with the PC's previous publications and its inquiry into *Harnessing data and digital technology*, regulators should use an outcomes-focused, stepped approach to consider how existing regulation can be applied and extended to AI, prior to developing new AI-specific regulation (BCA 2025; PC 2024c, pp. 5–8,

2025d). Part of this consideration is balancing sufficient regulatory protection with enabling the adoption of new technologies, which can lift quality of care. If new regulation is required, it should be risk-based and technology neutral to support adaptation to rapid technological change. AI-specific regulation can be considered as a last resort if technology-neutral regulation is not feasible or adequate to mitigate the risk of harm. Regulators should also be cognisant of international regulation and the risk of AI suppliers bypassing Australia if Australian standards depart from global norms (PC 2024c, pp. 9–11).

Lack of alignment alone should not be a barrier to pursuing worthwhile reforms

The previous section cautioned against introducing reforms that would create or further entrench silos. At the same time, where sector-specific regulation would bring net benefits to care users and the community, a lack of corresponding arrangements in other care sectors should not be a barrier to introducing it. The key is to ensure that governments consider the potential need for corresponding regulation in other sectors, and that the regulation is designed in a way that would allow for alignment if further regulation were introduced. This could involve, for example, ensuring that standards can be generalised or modularised to encompass the needs of multiple sectors.

Regulatory alignment is an ongoing process

Finally, reform of regulation will never be a ‘set and forget’ task. It must continue to evolve alongside the care system and broader economy and keep pace with the opportunities available from new technologies, including AI. And, as noted above, the reforms proposed in this chapter are only a first step towards the PC’s overarching vision for a quality and safety regulatory system that is aligned across all care sectors, levels of government and forms of regulation. At the end of the eight-year timeframe – or once our proposed actions have been completed – governments will need to review and revise its regulatory alignment agenda, so that reform can continue to improve the quality, efficiency and outcomes of services in the care economy to the benefit of care users.

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

Summary

- **Australia's care system is fragmented, with responsibility shared across multiple organisations working under different levels of government. Fragmentation creates duplication and gaps between parts of the care sector, reducing the productivity of care services and worsening outcomes for care users.**

- **Collaborative and place-based approaches – where organisations work in partnership to plan, procure and evaluate services – promote local autonomy and accountability that can focus services on local needs, reduce fragmentation across the health care system and foster innovative models of care.**

- **Governments should embed collaborative commissioning between Local Hospital Networks (LHNs) and Primary Health Networks (PHNs). Governments have already recognised the benefits of collaboration between these interdependent organisations, but blurred responsibilities and misaligned incentives have hampered its adoption across the system. Even when new collaborative models of care deliver positive outcomes, the current system does not allow them to be scaled or sustained.**
  - The benefits of embedding system-wide collaborative commissioning will vary across regions depending on the initiatives implemented, but we estimate this reform can reduce potentially preventable hospitalisations by 5% and emergency department presentations by 4%, equivalent to $600 million per year.

- **Strengthening collaboration requires reforms to joint governance arrangements and funding. The National Health Reform Agreement (NHRA) should be the main lever for embedding these reforms.**
  - LHNs and PHNs should jointly assess local needs, develop programs of work, monitor progress and report on outcomes using a nationally consistent framework, in partnership with ACCHOs and other organisations.
  - More funding flexibility is required to enable greater collaboration that addresses local needs.
  - Dedicated funding for collaborative programs to address local gaps in care is required. Funding based on the achievement of agreed shared outcomes would incentivise successful programs.
  - Governments should undertake supporting actions to enable access to data and build organisational capability to track outcomes and drive improvements.
  - Effective implementation of the full suite of reforms will require a staged approach. Most actions should be commenced quickly, but further work is required to develop dedicated outcomes-based funding.
  - These reforms are expected to produce higher quality and more efficient care and improve productivity by developing an ecosystem of collaboration that enables greater uptake of effective interventions.

Collaborative commissioning can improve outcomes

Poorly integrated care worsens outcomes for care users

Australia's care system is fragmented. Due in part to our federal system of government, multiple organisations work under different levels of government to provide services across different types of care. The siloed structure of care services – characterised by complex governance and fragmented funding arrangements – leads to inefficiencies and cost shifting, and makes it difficult for people to access comprehensive and coordinated support (Peiris et al. 2024). The National Rural Health Alliance submitted:

> The split funding model, where the Commonwealth subsidises Medicare services while states and territories fund hospitals and community health services, creates gaps, duplication and fragmentation in healthcare. Fragmented health care delivery is a barrier to improving health system performance and fosters silos, with one sector often offloading care and costs to another, rather than collaborating to improve efficiency and outcomes across the continuum of care. (sub. 178, p. 2)

Gaps in care often emerge at the interfaces between different parts of the system, such as acute, primary, disability and aged care. While fragmentation occurs across the care economy, it is especially prevalent within the health sector and at the interface between primary and acute care. This reflects several system design characteristics, including:

- the strong interdependency of the health sector, with activities in one part often having substantial effects on demands on other parts
- blurred responsibilities, overlap and substitution between the services provided by different parts of the sector – such as hospital emergency departments substituting for services provided by GPs
- split funding arrangements between the Australian and state and territory governments, which misaligns incentives and discourages collaboration.

These systemic issues are hard to shift, but maintaining the status quo has serious consequences. The burden of chronic disease in Australia is substantial and growing – one in five Australians live with two or more chronic conditions; and this proportion has increased (even after adjusting for population age structure changes over time) (AIHW 2024). Fragmented care poses significant risks for people with complex health needs who must navigate multiple healthcare settings. It also reduces efficiency and drives up costs for governments due to duplication and reduced ability to direct care users to more cost-effective pathways.

The Australian, state and territory governments have a long-standing ambition to improve integration within the health care system. The National Health Reform Agreement (NHRA), Primary Health Network (PHN) strategy and the National Mental Health and Suicide Prevention Agreement (which the Productivity Commission recently reviewed) all set out this objective.

In the absence of wholesale funding reform and realigned responsibilities within the federation, embedding collaborative commissioning is a practical reform to reduce fragmentation and bring the primary and acute parts of the health care system together. The reform builds on previous reviews which have stressed the need for governments to do more. The 2022 *Strengthening Medicare Taskforce Report* and the *Mid-Term Review of the National Health Reform Agreement Addendum 2020–2025* both recommended that PHNs work with Local Hospital Networks (LHNs)[13] and Aboriginal Community Controlled Health Organisations (ACCHOs), among others, to strengthen collaboration and integration (Australian Government 2023, p. 7;

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

Huxtable 2023, p. 69). The PC has previously reached similar conclusions about the need for LHNs and PHNs to collaborate more closely (2017b, p. 9, 2020a, p. 1134, 2025e, pp. 191–211).

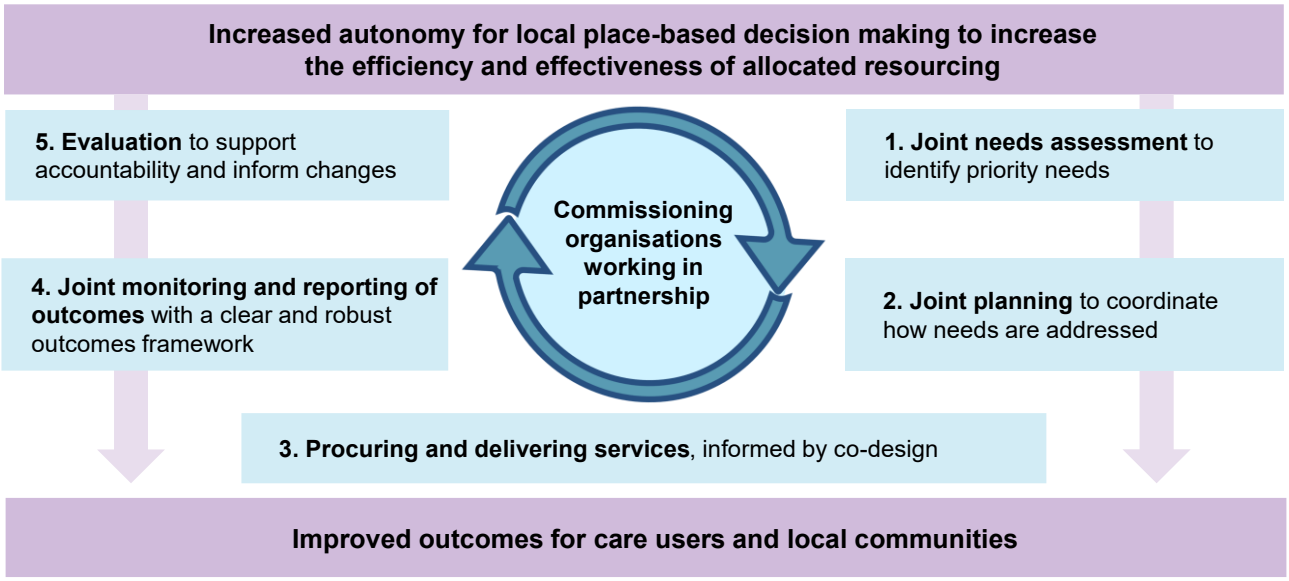
This chapter outlines tangible steps governments can take to remove system-wide barriers and increase collaboration between LHNs and PHNs in partnership with ACCHOs and other organisations.

Place-based collaborative commissioning can improve outcomes and save money

Collaborative commissioning describes organisations working in partnership to identify needs, design solutions, procure services and evaluate outcomes (figure 2.1). Collaborative commissioning is a more holistic approach than simply procurement: it is a continuous cycle that involves planning, design and evaluation of outcomes to inform future planning and refinement of service design.

Embedding collaborative commissioning in health care would support value-based care, generate savings, foster innovation and improve health outcomes.

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



Place-based collaborative commissioning can improve outcomes for care users

Collaborative commissioning can support better health outcomes through enabling more integrated care, addressing service gaps and tailoring care services to local needs. By bringing care systems together, it can break down silos between organisations and types of care, and contribute to a more seamless experience for care users, particularly people with chronic or complex conditions. Participants in the inquiry highlighted these benefits (PC 2025c, pp. 14–15).[14] The Grattan Institute said:

> 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. (qr. 56, pp. 1–2)

[14] AHHA (sub. 26, pp. 10–11), Uniting NSW.ACT (qr. 53, pp. 2–3), Health Consumers' Council WA (qr. 48, pp. 2–3), The Health Alliance (qr. 70, pp. 2–3).

A key feature of collaborative commissioning is that it can take a place-based approach to care services. Place-based approaches, which are increasingly adopted around the globe,[15] enable services to be coordinated and tailored to local needs, reducing the gaps in available services and making it easier for people to access them. A place-based approach can also empower local communities through reallocating decision-making and accountability for achieving outcomes.

ACCHOs embody an integrated place-based approach that embeds a flexible and responsive approach to care, and seeks to influence the social determinants of health:

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

Case studies of collaborative commissioning initiatives show that better integrated care at the local level can produce substantial gains. For example, it can improve patient outcomes by reducing hospitalisations. Programs that have reduced the need for hospital presentation or admission include a program for frail and older people in Northern Sydney (box 2.1), the Care Collective program between Metro North Health and Brisbane North PHN, and the Aged Care Emergency Service program in the Hunter New England region.

Box 2.1 – Collaborative commissioning can target priority populations, improve outcomes and save money: evidence from a program for frail and older people in Northern Sydney

The Northern Sydney Local Health District (LHD) and PHN co-designed a program to improve the management of frail and elderly people, aiming to enhance patient outcomes and reduce demand on emergency departments. Funding came through NSW Health's Collaborative Commissioning program.

The LHD and PHN undertook a needs assessment that identified older people as a priority cohort, finding a 12.5% increase in the number of people aged 75 and older using the emergency department between 2014 and 2019, far outpacing the population growth rate of 4.4%. It also found that the priority cohort could be better managed in the community through embedding existing LHD Hospital in the Home and Rapid Response programs in primary care.

How collaboration happened and why it worked

Collaboration enabled primary care providers and hospitals to better align their services. The PHN effectively engaged GPs to monitor high-risk hospital patients in the community and to integrate with LHD services. Integration was supported by financial incentives to GPs, streamlined communication across services and the identification of high-risk patients through shared data.

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

Box 2.1 – Collaborative commissioning can target priority populations, improve outcomes and save money: evidence from a program for frail and older people in Northern Sydney

Outcomes of the collaboration

This integrated approach to care meant that of 14,619 referrals to the LHD's Geriatric Rapid Response service between 2022 and 2024, 80% of patients were managed in the community without an emergency presentation within the week (Inglis et al. 2025).

Source: AHHA (2024).

Key success factors

The program's success was attributed to:

- the time the LHD and PHN invested in forming their partnership
- seed funding that enabled joint planning
- an iterative and data-led approach to service implementation
- change management support provided by the PHN.

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

Collaboration can also enable Aboriginal and Torres Strait Islander people to access more culturally appropriate care. For example, collaboration through the Institute for Urban Indigenous Health (IUIH) Birthing in Our Communities program has led to better health outcomes for Aboriginal and Torres Strait Islander people (box 2.2).

The Birthing in Our Communities program incorporates the experiences of Aboriginal and Torres Strait Islander women in its design. Collaborative approaches like these can support the delivery of care that meets the diverse needs of women:

> Women face distinct and compounding barriers when it comes to accessing quality health care, shaped by location, culture, socioeconomic status, disability, and gender norms. … Place-based approaches, designed with and by communities, ensure that services meet the diverse needs of women. (WwWA, WWDA, AMWA, and NATSIWA, sub. 126, pp. 14–15)

Box 2.2 – Collaborative commissioning can deliver better, more culturally appropriate care: the Birthing in Our Communities program

Culturally safe and appropriate antenatal health services are paramount to ensuring Aboriginal and Torres Strait Islander children are born healthy and strong (PC 2024b, p. 24). The Birthing in Our Communities (BiOC) program is a unique model of Indigenous-led maternity care that provides culturally informed maternal and infant health services for Aboriginal and Torres Strait Islander families. IUIH partners with Mater Health Services and Metro South Hospital and Health Service to deliver the program.

Enablers of the collaboration

The program involves Aboriginal and Torres Strait Islander governance and oversight through a steering committee and integrated service delivery with public and private health services. BiOC is part of IUIH's System of Care, which facilitates an integrated approach across local, system and community levels, providing regionally-managed but locally accessible programs (Turner et al. 2019, p. 426).

In a 2012 evaluation of antenatal services for Aboriginal and Torres Strait Islander women, women reported low satisfaction during and after birth and some women reported not feeling culturally safe (Kildea et al. 2021, p. 652). Through a co-design process, including an engagement workshop, the program was able to respond to the experiences and concerns raised, including through providing midwifery care up to six weeks after birth (Kildea et al. 2017, p. 231).

The program has improved outcomes and contributed to progress on Closing the Gap

The program contributes to progress toward Outcome 2 under the National Agreement on Closing the Gap: Aboriginal and Torres Strait Islander children are born healthy and strong. In particular, BiOC has proven to perform better than standard care on a range of national maternity indicators and has closed the gap in preterm births and birth weights.

It is estimated that through the BiOC program, relative to standard care, there has been a:

5.3 percentage point reduction
in preterm births for Aboriginal and Torres Strait Islander families

saving of $4,810
per mother baby pair

This program also contributes to progress toward Outcome 12: Aboriginal and Torres Strait Islander children are not overrepresented in the child protection system. The continued overrepresentation of Aboriginal and Torres Strait Islander children in the child protection system stems from the impacts of colonisation and dispossession including intergenerational trauma, systemic racism and inequality across social determinants of child wellbeing (Darwin et al. 2023; QFCC 2021; SNAICC 2023). The period of pregnancy and childbirth provides an opportunity to break such cycles of trauma (Chamberlain et al. 2019, p. 3). The BiOC program recognises the strengths of Aboriginal and Torres Strait Islander culture, community and kinship in supporting mothers and in the health and development of children. Babies of mothers that received BiOC care were three times less likely to be in out-of-home care from birth compared with those that received standard care, demonstrating the value of culturally appropriate programs (IUIH 2024; O'Dea et al. 2024).

Source: Gao et al. (2023); IUIH (2023, p. 15).

Collaborative commissioning can improve efficiency and productivity

Collaborative commissioning can also improve productivity through more efficient use of government funding. It can reduce both inefficient duplication and the need for costly services such as hospitalisations. For example:

> We see this particularly in patients who would be well served by seeing a GP but have instead presented to an emergency department either because they were unable to get an appointment with a GP, couldn't afford the upfront and/or out of pocket costs, or because the GP is closed. (Health Consumers' Council WA, qr. 48, pp. 2–3)

Examples of effective collaborative commissioning initiatives point to the efficiency benefits.

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

The efficiency benefits of collaboration can be especially valuable in regions that face workforce shortages and other 'thin market' issues. For instance, the PHN Cooperative submitted:

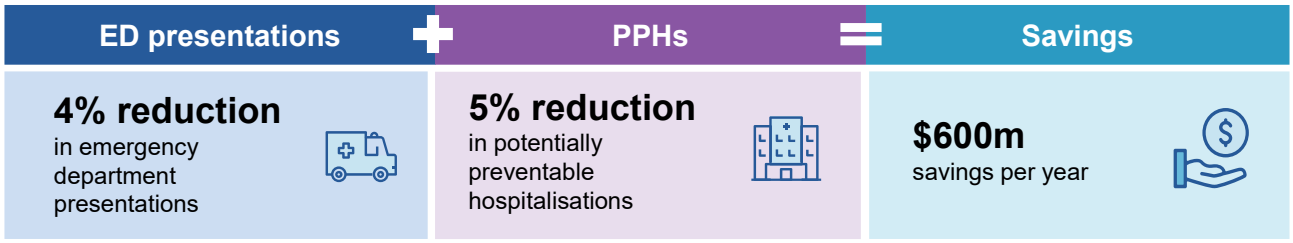
> More optimal use of a maldistributed health workforce can be achieved through collaborative commissioning, particularly in rural and remote areas or other places experiencing thin markets. (sub. 104, p. 5)

Collaborative commissioning can yield benefits beyond the freeing up of resources in the health system. For example, a healthier population will lead to increased workforce participation and labour productivity for both patients (Verikios et al. 2015) and carers.

Reform can expand the benefits of collaborative commissioning ...

The benefits of widespread adoption of collaborative commissioning are hard to quantify since they depend on the specific initiatives adopted by LHNs and PHNs. However, the PC estimates that our reforms can reduce PPHs by 5% and ED presentations by 4%, equivalent to $600 million per year (figure 2.2). This estimate does not consider the cost to the health care system of the programs required to avoid PPHs and ED presentations.

Figure 2.2 – Collaborative commissioning can save the health system through fewer emergency department presentations and potentially preventable hospitalisations



Source: PC estimates (calculations in appendix B).

This estimate does not include other benefits from a more integrated care system, such as reduced length of hospital stay, fewer readmissions and ambulance arrivals, and better outcomes for patients from less time spent unwell or in hospital.

However, realising the full extent of these benefits will require all LHNs and PHNs to work together with their counterparts in a similar manner to the successful cases explored in this chapter. It will also take time to realise the benefits, as experiences in the case studies show. Nevertheless, the benefits are likely to grow over time, producing greater savings as costs in the health system, such as the cost of bed days, increase.

… but it must overcome persistent barriers to collaboration

While individual initiatives show encouraging signs, progress towards a consistent, national approach to collaborative commissioning remains limited. Systemic barriers can frustrate rather than foster collaborative approaches. The barriers identified by participants often interplay and overlap (PC 2025c, pp. 16–17). They include:

- **Difficulty moving beyond trials**: Resources allocated to try new approaches tend to be for relatively small-scale trials or pilots with limited time frames. Secure and stable long-term support for proven effective programs is inadequate.
- **Rigid and short-term funding**: Funding processes do not suit the objectives of regional bodies such as PHNs and ACCHOs because they offer little flexibility to address local needs or certainty to sustain effective programs (Health Alliance, qr. 70, p. 3; Uniting NSW.ACT, qr. 53, p. 3; VACCHO 2024, pp. 51–53).
- **Capability constraints**: Prescriptive requirements and small budgets can limit the capacity of organisations to meet their objectives and prevent them from attracting, training and retaining staff. These constraints can affect the capacity of organisations to engage in collaborative commissioning.
- **The lack of formal joint governance architecture**: There is no authorising environment that makes collaborative approaches the default. Instead, collaboration occurs despite the system, and success relies on the motivation and goodwill of individuals. When these individuals leave, initiatives can cease.
- **Misaligned incentives**: Collaboration can be inhibited by siloed organisations and funding arrangements (AdPha, qr. 60, p. 4; CHA, qr. 65, p. 7), and by misaligned areas of geographical responsibility, such as boundary mismatches between some LHNs and PHNs.
- **Data and evaluation constraints**: Data-sharing arrangements can be difficult and time consuming to establish, frustrating opportunities to collaborate (Fixing the NDIS research team, Centre for Disability Research and Policy, The University of Sydney, qr. 31, p. 5; CHA, qr. 65, pp. 7–8).

Reform of governance and funding to embed collaborative commissioning

Embedding systemwide use of collaborative commissioning requires a comprehensive approach. To overcome systemic barriers that impede the broad adoption of collaborative practices, governments need to:

1. provide a more consistent and prescriptive approach to joint regional governance
2. increase the flexibility and certainty of funding
3. provide dedicated funding that incentivises collaboration
4. undertake supporting actions to provide strategic direction and guidance and enable access to data.

A consistent joint governance framework is needed

To expand successful collaborative commissioning, governments should strengthen the joint governance requirements they place on LHNs and PHNs. As the George Institute for Global Health submitted, 'reliance on goodwill alone is insufficient in an environment where there are competing priorities that can divert resources and attention' (sub. 154, p. 3). Participants expressed broad support for more formal joint governance requirements (for example, The Health Alliance, sub. 84, p. 5; PHN Cooperative, sub. 104, pp. 6–7; The George Institute for Global Health, sub. 154, p. 3).

The National Health Reform Agreement (NHRA) should be the main lever for embedding collaborative commissioning between LHNs and PHNs and strengthened joint governance arrangements should be included in the 2026 addendum. The NHRA provides a mechanism for Australian, state and territory governments to provide overarching strategic direction and creates an authorising environment that embeds collaboration as standard operating practice.

Strengthened joint governance requirements are consistent with the intent and ambition of the NHRA as it stands, but the 2020–2025 agreement falls short because it is aspirational, with insufficient detail and accountability to achieve tangible progress on collaboration between different parts of the health sector.

The midterm review of the NHRA recommended developing a nationally consistent governance framework to drive and enforce integration between PHNs, LHNs and ACCHOs. It also proposed minimum requirements for local planning and co-commissioning, shared and linked datasets, agreed programs of work and shared reporting and accountability outcomes (Huxtable 2023, recommendation 7). The PC's reform proposal, detailed below, is broadly consistent with that recommendation and builds on it.

If the 2026 addendum to the NHRA does not go as far as the reforms proposed below, governments should increase efforts through bilateral arrangements and provide some interim resourcing, to support stronger joint governance and ensure that progress does not stall. Arrangements such as the Queensland-Commonwealth Partnership (QCP) (box 2.4) demonstrate the scope for governments to do more to facilitate collaboration under the current settings. To embed a consistent national approach to collaboration, however, the ambition should remain to make the NHRA more prescriptive in the next addendum.

Joint committee arrangements are needed to strengthen collaboration

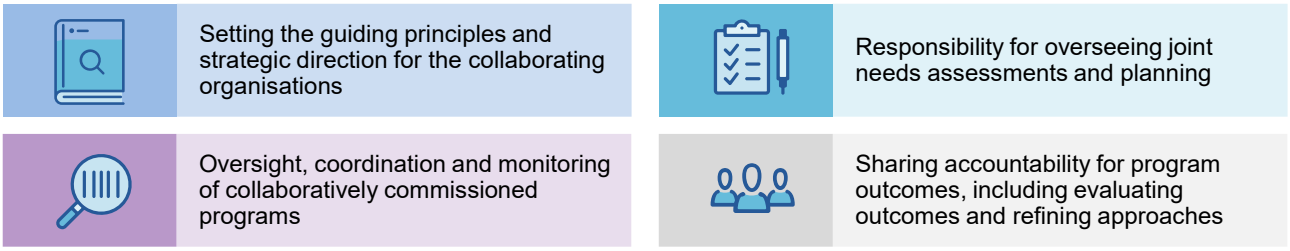
Formalised engagement processes should underpin stronger collaborative arrangements. Under the NHRA, LHNs and PHNs are expected to have overlapping board composition and establish formal engagement protocols, but these expectations are not having enough effect and collaboration varies as a result.

Joint committees or boards have been critical in previous instances of collaborative commissioning. The Patient Centred Co-commissioning Groups formed under the NSW Collaborative Commissioning initiative is

one example (NSW Health 2024b). Similarly, the Health Alliance, a joint initiative between Brisbane North PHN and Metro North Health, is governed by a joint board committee that includes the board chairs and chief executives of both organisations (The Health Alliance 2025).

LHNs and PHNs need to form joint committees to oversee collaborative commissioning activities (figure 2.3).

Figure 2.3 – Joint committees should have the following scope



Joint committees should meet regularly and have a chain of accountability that encourages all levels of the organisations to collaborate. This could include boards comprising the senior management of collaborating parties and joint working groups that focus on specific activities.

In addition to LHN and PHN members, these committees should include representatives of ACCHOs, other care sectors, service providers and relevant independent experts, where practicable. When forming these committees, the organisations' other consultative committees and arrangements should also be considered.

To improve health outcomes for Aboriginal and Torres Strait Islander people and achieve progress towards the targets in the National Agreement on Closing the Gap, growth in the ACCHO sector is needed (NACCHO, sub. 215, pp. 16–17). Such expansion could reduce the role of mainstream organisations (such as PHNs) in commissioning or delivering services for Aboriginal and Torres Strait Islander people. However, hospitals and other mainstream organisations still need to partner in the provision of services for Aboriginal and Torres Strait Islander people.

These partnerships already occur to varying extents, but partnerships between LHNs, PHNs and ACCHOs should be formalised in a way consistent with Priority Reform Three under the National Agreement on Closing the Gap that reflects the role of ACCHOs as essential partners in program and service design and implementation and enables shared decision-making. These formal partnership requirements will need to allow for flexible approaches to account for local preferences and capability. For example, the South West Queensland Primary Health Care Alliance Leadership Team includes representatives from a wide range of partners in the region (box 2.5).

Joint planning to guide collaboration

Stronger joint planning processes would enable LHNs and PHNs to understand the priority needs of their populations, plan how they will collaborate and evaluate whether intended care outcomes are achieved.

To varying extents, LHNs and PHNs already undertake joint regional planning for mental health and suicide prevention services under the National Mental Health and Suicide Prevention Agreement. But approaches to this planning have been inconsistent. In its review of the Agreement, the PC (2025e, pp. 99–101) recommended that national guidelines on regional commissioning and planning be released before June 2026. Joint planning processes should be extended to all areas of mutual interest between LHNs and PHNs.

A joint needs assessment to identify priority needs

LHNs and PHNs, in partnership with ACCHOs and other relevant organisations, such as local government, should undertake joint needs assessments to identify the health needs of their region and how they vary from national averages. For example, a particular region might have a relatively high population of older and frail residents, high rates of smoking, low rates of vaccination, and/or a significant population with a specific chronic disease. Assessments must consider whether the health needs of the population are being met and if there are service gaps preventing people from receiving appropriate, timely and efficient care (boxes 2.1 and 2.5 illustrate priority areas identified through needs assessments). Partnership with ACCHOs could include ACCHOs leading regional needs assessments for Aboriginal and Torres Strait Islander people (box 2.3).

Box 2.3 – LHNs and PHNs need to partner with ACCHOs and other organisations

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

The Institute for Urban Indigenous Health (IUIH 2023, p. 19) previously proposed that governments contract ACCHOs to conduct needs assessments, separate from existing service delivery contracts, and that governments provide sufficiently disaggregated data to support this work. IUIH identified ACCHOs as best placed to lead this work, since needs assessments by LHNs and PHNs lack meaningful community engagement, and subsume Aboriginal and Torres Strait Islander needs within broader priorities.

A formalised role for ACCHOs in leading regional needs assessments should support the objective of increasing the share of services delivered by Aboriginal and Torres Strait Islander organisations. These assessments could then inform the community-wide joint assessments undertaken by LHNs and PHNs.

ACCHOs will need to have the capacity to undertake these assessments. ACCHOs vary in size, scope and geographical coverage, so a flexible approach that is responsive to the capacity and preferences of local organisations and communities will be needed. In some instances, coordination at a regional or state and territory level may be the preferred approach.

LHNs and PHNs typically undertake their own needs assessment (or equivalent process), often for the same or overlapping areas. This duplicates effort and makes assessments less comprehensive than they could be. While each organisation's planning responsibilities extend beyond the scope of collaboration, joint assessments that address areas of mutual interest have proven effective in supporting a place-based and targeted approach to service delivery (Quigley et al. 2024).[16]

One complication in establishing collaborative commissioning is that the boundaries between LHNs and PHNs do not always align, despite the long-standing intent spelled out in the NHRA. There is also boundary misalignment with other organisations, including ACCHOs, adding to complexity. In the longer term, there

[16] The effectiveness of joint needs assessments has also been shown in the United Kingdom (Asmar et al. 2024, p. 12).

could be benefits from greater alignment of boundaries between LHNs and PHNs, but the current misalignment does not preclude establishing collaborative arrangements with multiple different parties.

Examples of organisations adopting a joint needs assessment approach include those under the QCP (box 2.4) and the NSW Collaborative Commissioning program (box 2.1).[17]

Box 2.4 – Governance arrangements that support joint planning: the Queensland-Commonwealth Partnership

The QCP is a shared commitment from partners across Queensland to move towards an integrated, patient-centred and equitable health system. The partnership involves Hospital and Health Services (HHSs), PHNs, ACCHOs and inter-jurisdictional government partners: the Queensland Department of Health and the Australian Government Department of Health, Disability and Ageing. It features joint regional needs assessments, shared data requirements, joint planning and an accountable governance framework.

Legislative reform has recognised the Queensland Aboriginal and Islander Health Council, the Institute for Urban Indigenous Health and Queensland PHNs as prescribed entities governing Queensland Health data.

The QCP has replaced individual HHS and PHN needs assessments with joint regional needs assessments. A co-designed framework provides a basis to identify shared priorities and inform opportunities for collaborative commissioning. Regions have flexibility to select outcomes relevant to their areas.

Key phases and features of the QCP approach

The framework sets out four common phases:

- establish the geographic region, governance and engagement plans
- collect and analyse data and conduct engagement
- validate and triangulate data
- prioritise health and service needs and assign lead agencies.

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

The QCP approach provides a good model that could be extended to all states and territories, although flexibility will be required to account for different LHN and PHN boundary alignment across jurisdictions.

Under the proposed arrangements, joint needs assessments should incorporate the features outlined in figure 2.4.

[17] The Central Coast Health Alliance, which includes the Central Coast Local Health District and Hunter New England and Central Coast PHN, has also developed a joint strategic needs assessment (Quigley et al. 2024).

Figure 2.4 – Joint needs assessments should incorporate these features

Developing an agreed program of work

While joint needs assessments identify priority areas for focus, addressing them requires LHNs and PHNs to jointly develop an agreed program of work. At present, work plans are often developed independently, risking duplication or a lack of strategic cooperation. A coordinated approach can improve accountability and outcomes.

The agreed program of work should reflect local needs, priorities and constraints (as demonstrated in boxes 2.1, 2.2 and 2.5). It should outline the roles and responsibilities of relevant organisations, procurement processes and funding sources – including how funds are to be pooled, where relevant. The program of work should also establish the outcomes to be targeted.

The program should be developed in partnership with the community, service providers and other relevant organisations, including ACCHOs. The South West Primary Health Care Alliance is an example of this whole-of-system approach to planning (box 2.5).

Box 2.5 – Governance arrangements that enable pooled funding and integration: the South West Primary Health Care Alliance

The South West Primary Health Care Alliance seeks to provide whole-of-system governance for integrated primary care throughout South West Queensland. It is a partnership between the Western Queensland PHN, South West Hospital and Health Service (HHS), Cunnamulla Aboriginal Corporation for Health, Charleville & Western Areas Aboriginal & Torres Strait Islanders Community Health, Goondir Health Services and other regional partners.

The partnership involves clear roles and responsibilities, whole-of-system planning and pooled funding. An Alliance Leadership Team with representatives from member organisations decides upon joint objectives, scope and work plans.

Progress to date

The Alliance has supported collaborative partnerships, including the Nukal Murra Alliance, between four ACCHOs and the Western Queensland PHN, and the preparation of joint regional needs assessments

Box 2.5 – Governance arrangements that enable pooled funding and integration: the South West Primary Health Care Alliance

by the Western Queensland PHN and constituent HHSs in 2024. The joint regional needs assessments follow the QCP framework. For example, South West HHS and the Western Queensland PHN identified 14 health and 38 service needs for their local community. Identifying these needs, including healthcare needs for an ageing population and culturally appropriate child and maternal services, was made easier by whole-of-system planning and the delivery of integrated care. The Alliance has also developed a Workforce Implementation Plan Strategy to reverse the decline in the region's permanent GP workforce, identify gaps in primary care services and enable digital interoperability.

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

Joint monitoring and reporting of outcomes

Joint monitoring and reporting of outcomes is necessary to evaluate the success of initiatives undertaken by LHNs and PHNs. Joint monitoring and reporting also ensures local decision makers are accountable, which underpins the autonomy they need to realise the benefits of place-based collaborative commissioning.

Evaluating joint regional health systems and integrated initiatives is highly complex (Crocker et al. 2020, p. 7; Impact Co. and QCP 2024b, p. 79). Yet experience from other jurisdictions, such as the United Kingdom, indicates that a joint outcomes framework can strengthen oversight and accountability while supporting better health outcomes through local decision-making.[18]

A nationally consistent outcomes framework is needed to calibrate the reporting obligations for commissioning organisations. It should draw on national reporting frameworks, including the Australian Health Performance Framework[19], which is designed to support system-wide reporting of health and health care performance, and the Aboriginal and Torres Strait Islander Health Performance Framework. It could also be aligned with the Quintuple Aim, which health organisations already use widely (The Health Alliance, sub. 84, p. 6).

To the extent that current performance measures and reporting obligations placed on commissioning organisations are inconsistent with these national outcomes and indicators, relevant governments should revise them and adopt common metrics.

While collaborative approaches and programs will vary, reporting should enable nationally consistent comparisons so that successful new initiatives can be identified. Reporting will also be essential to inform the outcomes-based funding proposed below. However, it should not duplicate or unduly increase the reporting burden on commissioning organisations.

[18] The King's Fund and Nuffield Trust recommended the UK National Health Service (NHS) adopt a single outcomes framework to support joint initiatives between health bodies (Goodwin et al. 2012, pp. 8, 12–13). A new NHS oversight framework was adopted in 2025 and describes a consistent and transparent approach to assessing integrated care boards, NHS trusts and foundation trusts (NHS England 2025).

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

Interim resourcing may be needed to progress joint governance

The joint governance arrangements outlined should ideally be established in the NHRA, as noted above. If the strengthened joint governance arrangements are not included in the 2026 addendum to the NHRA, however, progress towards implementation should not be delayed. The Australian Government should provide some initial resourcing, potentially on a matched basis with state and territory governments, to ensure that LHNs and PHNs have sufficient resourcing to participate in the joint governance arrangements outlined in this report.

These additional interim resourcing requirements are not expected to be substantial. In some cases, the proposed joint governance arrangements will formalise or replace practices already resourced by LHNs and PHNs. In other cases, a move to joint governance arrangements may be more resource intensive, particularly where collaboration is more complicated, such as through boundary misalignment. The PHN Cooperative reinforced this point:

> 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. (sub. 104, p. 8)

Similarly, sufficient resourcing and time will be required for ACCHOs and other organisations to participate as genuine partners in this process. Additional resourcing may also be needed to improve data access and capability (discussed below). The resourcing for governance arrangements discussed here is separate to the proposed dedicated funding for commissioned services (discussed below).

Recommendation 2.1
Establish stronger joint governance arrangements

Governments should agree to establish stronger joint governance arrangements that 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.

- LHNs and PHNs should be required to plan together to identify areas for collaboration, including joint needs assessments, agreed plans of work and joint monitoring and reporting of outcomes.
- LHNs and PHNs should work in partnership with ACCHOs and other organisations to inform planning and shared decision-making. Partnering with ACCHOs should be consistent with the principles set out in the National Agreement on Closing the Gap to ensure relevant needs are appropriately and respectfully assessed and decisions shared.
- Stronger requirements for formal joint committees to provide oversight and accountability for collaboration are needed.

The National Health Reform Agreement (NHRA) should be the main lever for moving beyond pilots and embedding these reforms, augmented by additional actions outside the agreement where necessary.

- If the 2026 addendum to the NHRA is not sufficiently prescriptive, the Australian Government should allocate some initial resourcing, potentially on a matched basis with state and territory governments, to progress the development of joint governance arrangements through bilateral agreements.

Funding should provide certainty and flexibility

Funding should be flexible to allow for more collaborative commissioning

LHNs and PHNs require flexibility to collaboratively commission services that meet local needs, but current funding arrangements often limit what they can do (NSW Health 2025). For example, under the current approach, a large proportion of PHN funding is earmarked for specific initiatives, leaving PHNs with limited scope to tailor services to local needs and constraining collaboration with LHNs or ACCHOs.

Funding to PHNs – be it new funding (discussed below) or existing categories where appropriate, such as funding for mental health and suicide prevention (PC 2025e, p. 195) or chronic disease – should be flexible enough to support the commissioning of services that respond to local priorities identified through joint needs assessments. National consistency may be warranted for some PHN programs but should be the exception and only when informed by rigorous evaluation. PHNs should also have flexibility to collaborate with local organisations that are best placed to address local needs; whether it be GPs, ACCHOs, and/or alcohol and other drug treatment services.

Greater flexibility has been widely supported by inquiry participants and others (Breadon et al. 2022, pp. 4, 61; PC 2025c, p. 20).

Guardrails around more flexible funding are needed to support local decision-making and ensure that PHNs are accountable for delivering outcomes as specified by the Department of Health, Disability and Ageing. These guardrails include the governance arrangements outlined above: joint committees, joint planning and strengthened monitoring and reporting of outcomes.

LHN funding should also be flexible enough to support collaboration. Service agreements with state and territory governments should not unduly constrain LHN activities, and legislative barriers should be removed so that they can fund collaboratively commissioned services. For example, LHNs should be able to fund collaboratively commissioned services in primary care, including prevention activities and the management of patients with chronic conditions. At present, LHNs are effectively precluded from funding or commissioning GPs as Medicare payments are not available to services delivered by a state agency such as an LHN (PC 2017a, p. 63).

Funding should support longer-term programs

To embed collaborative commissioning, PHNs require secure, longer-term funding that is periodically reviewed. The Salvation Army Australia (qr. 24, p. 3) submitted that ‘short-term funding agreements and design periods are not conducive to developing robust service delivery frameworks which provide the most effective assistance’.

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

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

Recommendation 2.2
Enable more flexible funding

Governments should facilitate collaborative commissioning by making funding more flexible.

- The Australian Government should allow Primary Health Networks (PHNs) to have flexibility in how they achieve agreed outcomes.
- To enable collaboratively commissioned programs, state and territory governments should ensure that service agreements provide flexibility in the services and programs that Local Hospital Networks (LHNs) can fund.
- Both LHNs and PHNs should be allowed to pool funds that are being used to support collaboration.

Flexibility should be accompanied by appropriate guardrails to maintain accountability for achieving outcomes.

Dedicated funding for collaborative commissioning is required

In addition to more flexible and longer-term grants for existing activities, dedicated funding for collaborative commissioning is required. Appropriately designing this funding will require some consideration, and it should therefore be embedded in the NHRA expected to commence in 2031. Nevertheless, given collaborative commissioning programs can provide significant value, governments should look for opportunities to fund them in the interim. In particular, changes to governance and funding flexibility (recommendations 2.1 and 2.2) will create valuable opportunities to identify new and innovative ways of addressing local needs. Governments should fund such programs based on their merit through existing processes.

The next addendum to the NHRA should include dedicated funding for collaborative commissioning

In the longer term, dedicated funding for collaborative commissioning should be included as part of the next NHRA expected to commence in 2031. The level of dedicated funding could be modest. Depending on the specific programs undertaken, the PC estimates that funding of about $150 to $200 million per year would be enough to undertake at least one ongoing program in each catchment across the country. The funding could be new or reallocated from other activities within existing LHN and PHN budgets. Some areas could deliver more than one program: The Health Alliance (sub. 84, p. 7) submitted that funding of $5 million to the Brisbane North PHN – which equates to approximately $120 million Australia-wide – would ‘allow for 2-3 service delivery programs at a reasonable scale’. Funding should be distributed to regions on a risk-based capitation basis, which acknowledges that health needs vary across Australia. The PHN Cooperative’s submission (sub. 104, p. 8) noted that current funding to PHNs is already subject to a formula that considers differing needs.

LHNs and PHNs should be able to access this dedicated funding by submitting their joint needs assessment and agreed program of work – including shared outcomes – to the Department of Health, Disability and Ageing. Outcomes should clearly link to reducing future costs, such as reduced potentially preventable hospitalisations. LHNs and PHNs would have flexibility in how they use this funding, but it should be directed towards collaborative programs that improve agreed joint outcomes. The dedicated funding should be divided between LHNs and PHNs in a ratio that reflects the division of responsibility outlined in their agreed program of work.

Outcomes-based funding is key to longer-term success

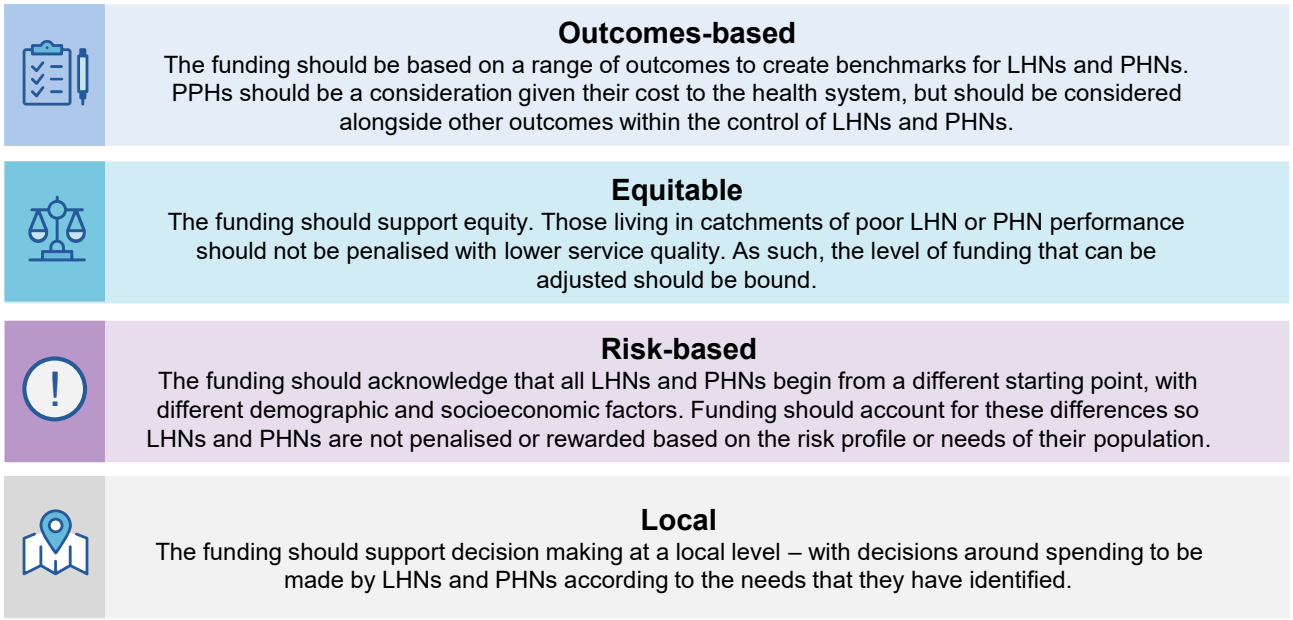
The amount of dedicated funding available for LHNs and PHNs should be adjusted based on the success of the collaborating organisations in meeting their shared outcomes. This approach would incentivise effective

collaboration and enable ongoing funding for successful programs, while also providing an accountability mechanism that encourages innovative local approaches and curtails spending on ineffective programs. The Australian Healthcare and Hospitals Association (sub. 26, p. 11) submitted that partnerships backed by 'funding models that incentivise outcomes … create a culture of joint accountability across the system'.

Designing outcomes-based funding that accurately targets performance will be challenging, not least because LHNs and PHNs share responsibility for health outcomes in their local areas. The shared outcomes framework will be central to the funding, enabling benchmarks to be set and determining whether they are met.

We propose that the Independent Health and Aged Care Pricing Authority (IHACPA) work with governments to design outcomes-based funding for collaborative commissioning. The funding should be agreed as part of the next NHRA, expected to commence in 2031. In doing so, IHACPA should consider the principles outlined in figure 2.5.

Figure 2.5 – Four principles to guide effective outcomes-based funding



Financial incentives of this nature have precedents. The review of the NHRA recommended that it should 'prioritise the development of optimal models of care, using agreed innovative financing mechanisms' (Huxtable 2023, p. 78) to shape demand for health services, such as potentially preventable hospitalisations. And recent funding and pricing reforms have introduced incentives for public hospitals to reduce hospital acquired complications, avoidable hospital readmissions and sentinel events (IHACPA 2025).

Recommendation 2.3
Provide dedicated funding based on outcomes

Stronger joint governance and increased funding flexibility are unlikely to be enough to embed collaborative commissioning across all regions of Australia; additional impetus is required, given the changes involved.

Governments should agree to outcomes-based dedicated funding arrangements that help Local Hospital Networks (LHNs) and Primary Health Networks (PHNs) to better collaborate, in partnership with Aboriginal Community Controlled Health Organisations and other organisations.

- Once a joint plan is submitted to the Department of Health, Disability and Ageing, the Australian, state and territory governments should provide LHNs and PHNs with sufficient dedicated funding to embed collaborative commissioning programs. The joint plan should clearly link agreed shared outcomes to enhanced productivity in the form of quality improvements or more services that lower future costs.
- Future funding should be based on the achievement of agreed shared outcomes – such as reduced potentially preventable hospitalisations – at the local level.

The Independent Health and Aged Care Pricing Authority should be immediately tasked with leading work to design the outcomes-based funding mechanism, to enable this approach to be implemented in the addendum to the National Health Reform Agreement expected to commence in 2031.

Governments need to provide guidance, enable data reform and strengthen organisational capability

While the NHRA should be more detailed and prescriptive, governments will also need to provide additional guidance on how collaborative arrangements would work in practice and lead reform to enable data sharing and the strengthening of organisational capability. In doing so, governments need to build on the lessons from initiatives to date, such as the NSW Collaborative Commissioning program and the QCP, to embed collaboration between organisations and with local place-based decision makers.

National guidelines and strategic direction by states and territories

Stronger national guidelines and tailored state and territory-based partnerships would help broaden collaborative commissioning. National guidelines for health regional commissioning, focusing on LHNs, PHNs and ACCHOs, would provide clarity and consistency to enable more effective commissioning capability. This guidance could expand on the approach in the National Mental Health and Suicide Prevention Agreement, where governments agreed to develop national guidelines on regional commissioning and planning (PC 2025e, pp. 99–101).

Partnerships between the Australian, and state and territory governments that identify joint strategic priorities and form shared commitments may also be needed. The QCP, for example, has provided a mechanism that supports the implementation of data sharing reform and joint regional needs assessments. Approaches across jurisdictions will need to be tailored to reflect different arrangements, strategic priorities and current initiatives.

State and territory health departments will play a key role in leading change. They should provide direction and leadership to LHNs to embed collaboration with PHNs, ACCHOs and other key partners. This should include supporting the rollout of joint regional needs assessments and providing an environment for LHNs to engage in new joint commissioning models.

Streamlined data sharing and linked datasets

Data sharing between commissioning organisations is essential to support the development of joint needs assessments, identify appropriate outcome measures, assess the effectiveness of commissioned programs, and undertake many collaboratively commissioned services. But current data sharing is inconsistent, and where it does occur, takes significant time and resources to establish. The PC heard that organisations face substantial barriers to sharing and accessing data, even within an organisation and when retrieving data they initially collected and provided. Those barriers were attributed to a range of technical and legal constraints, and privacy and other concerns. For example, the PHN Cooperative (sub. 104, p. 7) reported significant delays in the release of patient data to inform evaluations and claimed that systems have not supported monitoring patient outcomes in a way that enables timely collaboration. KPMG Australia highlighted the need for timely data to 'not only support retrospective performance reporting but also real-time decision-making and adaptive funding' (sub. 115, p. 6).

The importance of data sharing in successful collaborative commissioning has been evident through both the QCP (box 2.4) and the NSW Collaborative Commissioning initiative. For example, under the NSW Collaborative Commissioning initiative, data analytics supported by the Lumos program links de-identified data from general practices with other health service data to build an evidence base about patient pathways (NSW Health 2024a).

The recommendations of the NHRA mid-term review identified the need for data sharing, including linked datasets on population and service utilisation at the local level, where possible (Huxtable 2023, p. 69). The PC agrees with this recommendation. To achieve this goal:

- the NHRA needs to provide an authorising environment for consistent data collection and sharing that supports the outcomes and indicators in the national health performance frameworks
- Australian, state and territory governments need to remove impediments to accessing data across agencies and organisations, while maintaining appropriate guardrails around privacy and following Indigenous Data Sovereignty principles, to facilitate more streamlined data sharing and linked datasets.

Providing better access to data, including by removing any legislative impediments, will be important to enable more collaborative commissioning and integration across the care sector. It would also improve the general capability of organisations and strengthen innovation in the delivery of care.

Strengthened departmental capability

To drive change and effectively monitor compliance and performance, Australian, state and territory governments must strengthen their capabilities. The opportunity for stronger commissioning capability was highlighted by the Grattan Institute (sub. 71, pp. 3–4), which recommended that federal and state departments and PHNs adopt a systematic program to build commissioning capability.

To fulfil its coordination and leadership role, the Department of Health, Disability and Ageing must ensure its own systems are appropriately resourced and fit-for-purpose. The Australian National Audit Office's performance audit report, *Effectiveness of the Department of Health and Aged Care's Performance Management of Primary Health Networks* (ANAO 2024), highlighted the changes needed to ensure appropriate monitoring of the compliance and performance of PHNs and that the PHN delivery model is meeting its objectives. Recommendations included the implementation of a fit-for-purpose IT system for administering PHNs (recommendation 7) and the evaluation of the PHN delivery model to determine whether it is achieving its objective (recommendation 8). The subsequent *Review of Primary Health Network Business Model and Mental Health Flexible Funding Model* should be used to inform changes that ensure PHNs are structured to achieve their objectives.

Training and support programs for LHNs and PHNs

Australian, state and territory governments need to implement training and support programs to upskill LHN and PHN staff in leadership, codesign practices and data capability. These programs will strengthen the commissioning capability of LHNs and PHNs and help them collaborate with other organisations and the community. In setting appropriate resourcing for commissioning organisations, governments should consider the need to build capability in best practice commissioning.

Approaches from other jurisdictions, such as the United Kingdom, may be useful reference points for strengthening capability (Grattan Institute, sub. 71, p. 4).[20] Support through standardised approaches, such as automated data outputs for joint needs assessments and national guidelines for health regional commissioning and planning, would complement training programs to lift capability across commissioning bodies. Greater use of relational contracting practices in commissioning would also increase collaboration with service providers and communities (CPD, sub. 244, p. 7) and prioritise flexibility to achieve outcomes (Melbourne Disability Institute, Australian Welfare and Work Lab – University of Melbourne, sub. 107, p. 3).

LHNs and PHNs also need to change the way they work with Aboriginal and Torres Strait Islander people, consistent with Priority Reform Three of the National Agreement on Closing the Gap. They need to ensure that their organisations and the services they fund are culturally safe and responsive to the needs of Aboriginal and Torres Strait Islander people. The National Aboriginal Community Controlled Health Organisation (sub. 32, p. 10) has called for the PHN Guiding Principles for working with ACCHOs, which were established in March 2016, to be updated to align with the National Agreement on Closing the Gap.

Recommendation 2.4
Take a strategic leadership role and ensure sufficient capability

Governments have a strategic leadership role in implementing reforms to embed collaborative commissioning. Australian, state and territory governments should ensure that all relevant departments, agencies and commissioning organisations have the required capability to support collaborative commissioning. Governments should:

- remove impediments to accessing data to facilitate more streamlined data sharing and linked datasets, and drive a focus on outcomes
- ensure there is appropriate resourcing and capability to monitor compliance and performance of LHNs and PHNs to support greater autonomy
- provide training and support programs to LHNs and PHNs in leadership, co-design, cultural safety practices and data capability.

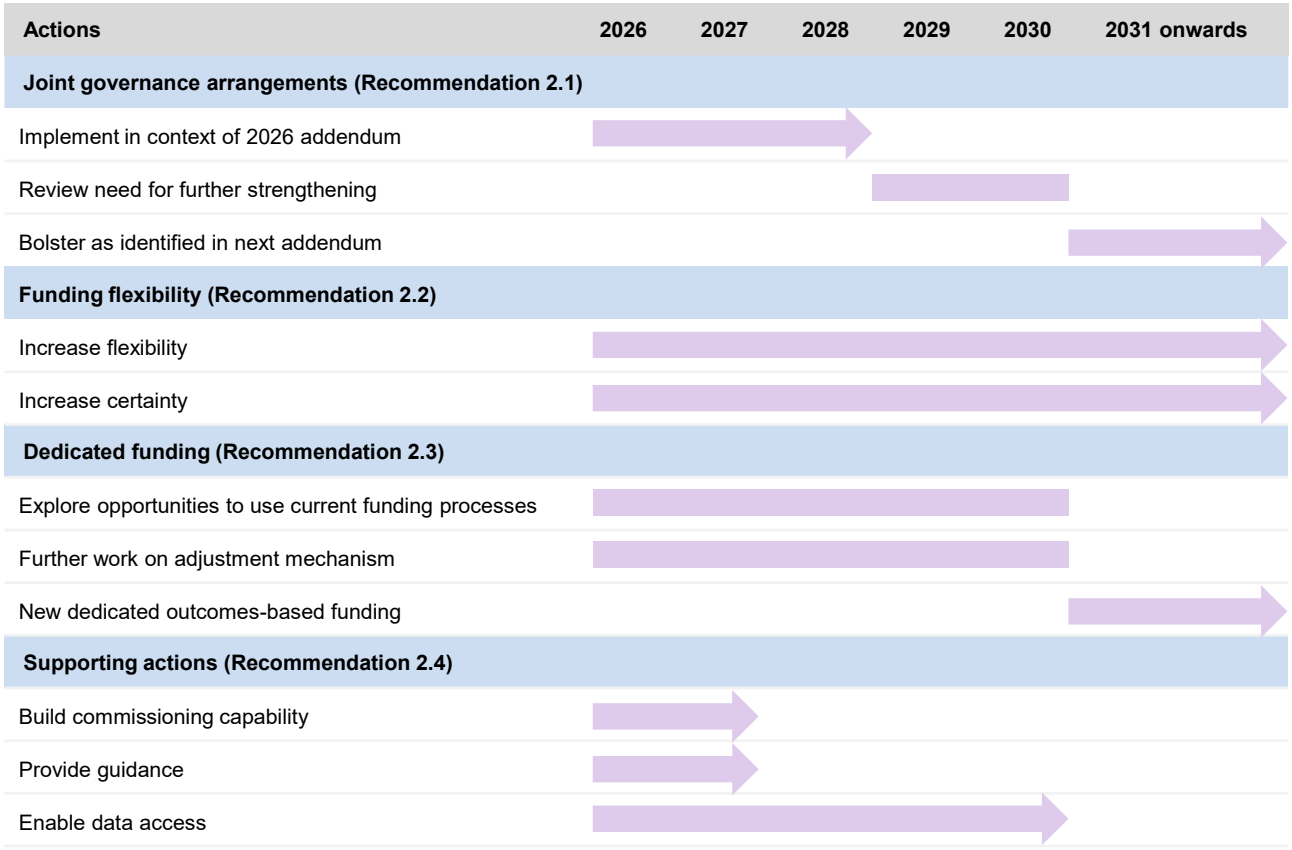
Where necessary, bilateral agreements between the Australian and state and territory governments to progress joint governance arrangements (recommendation 2.1) should be harnessed to progress these actions.

[20] Examples from the UK NHS include the Commissioning Support Units, which provide specialist skills and knowledge to commissioners, and the 'World class commissioning' program, which identified 11 competencies that commissioners were expected to demonstrate (NHS England 2007, 2024).

Effective implementation will require a staged approach

Effectively embedding collaborative commissioning will require implementation to be staged (figure 2.6).

Figure 2.6 – A staged approach to implementing the reforms



Some of these proposed actions can be taken immediately, with the Department of Health, Disability and Ageing coordinating and stewarding the reform. Governments must first embed the joint governance arrangements. If the 2026 addendum to the NHRA currently under negotiation is less prescriptive than proposed here, then the supporting guidance and bilateral Commonwealth and state and territory partnerships will need to incorporate the governance reforms in the short term so that progress does not stall. Further assessment will then be necessary to determine what needs to be strengthened or added in future addenda.

Reforms to ensure certainty and flexibility of funding and other supporting actions to enable data sharing and lift capability can also be progressed immediately.

The dedicated outcomes-based funding should be implemented in the second stage of reform and included in the next addendum to the NHRA, expected to commence in 2031. To support this, IHACPA needs to begin designing the outcomes-based funding mechanism in the near term.

Staging the reform in this way acknowledges that collaborative relationships and supporting arrangements are at different stages in different places. For LHNs and PHNs that are ready, the increased funding certainty and flexibility will enable them to implement collaboratively commissioned programs in the near term. It will also give other LHNs and PHNs time to build relationships with their counterparts, develop partnerships with ACCHOs and other organisations, and put in place the required supporting infrastructure, such as data sharing or other capability improvements.

Collaborative commissioning is a key piece of the reform puzzle

Our proposed reform has potential to deliver better outcomes, more efficient care and improve productivity by developing an ecosystem of collaboration that enables greater uptake of effective interventions across the country. That said, collaborative commissioning between LHNs and PHNs is just one part of the broader reform puzzle. Across the care economy, there is scope for more integrated care and collaborative place-based decision-making, including through formal relational contracting and expanding the collaboration to include local providers (as recommended by: BSL, sub. 180, p. 5; CPD, sub. 244, p. 7; Melbourne Disability Institute, Australian Welfare and Work Lab – University of Melbourne, sub. 107, p. 3).

The reforms can also be expanded to encompass greater integration with the disability and aged care sectors, as well as other social services. Such reforms are likely to be particularly beneficial in places where thin markets and workforce issues increase the need to coordinate the use of resources.

The PHN Cooperative highlighted the opportunity:

> There is enormous potential, if genuine collaborative commissioning arrangements are embedded at a regional level to jointly address other health challenges through an integrated one system approach. … More broadly robust governance structures established through this process could also support liaison between PHNs, LHNs and other care sectors, particularly aged care and disability services to achieve whole of government outcomes for particular underserved priority populations. (sub. 104, p. 9)

Other reforms – such as changes to funding models that focus on outcomes rather than activity (PC 2025c, p. 31), or changes to the way sectors of the care economy are administered – will be required to fully realise the benefits of collaborative commissioning and to expand their use. However, the PC's proposed reforms for increased collaboration between LHNs and PHNs, in partnership with ACCHOs and other organisations should be pursued irrespective of progress in these other areas. The reforms will produce substantial gains through both greater efficiency and better outcomes for people, and provide a demonstrable foundation for expanding collaboration and integration over time.

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

Summary

- **Investment in prevention and early intervention can produce significant benefits to individuals, government and the community. These investments can slow the growth in government care expenditure while simultaneously improving care outcomes.**
- **Australian, state and territory governments have recognised the need for greater prevention and early intervention efforts. But silos within government, short-term budget cycles, limited evaluations and scepticism that programs will deliver fiscal savings pose barriers to sufficient government investment.**
- **A National Prevention and Early Intervention Framework would support government investment in effective prevention and early intervention programs, improving outcomes for individuals, benefiting the wider community and reducing future demand for services. The framework would:**
  - recognise that the benefits of prevention and early intervention can take a long time to materialise and may not align with budget cycles, government departments or tiers of government
  - establish a robust assessment and evaluation process to ensure investment is in effective programs that deliver long-term benefits.
- **The National Prevention and Early Intervention Framework would be supported by:**
  - an independent advisory Board that reviews and recommends proposed prevention and early intervention programs for funding and advises on estimates of future benefits
  - a prevention and early intervention assessment team to build government capability and support the standardised economic evaluation of prevention and early intervention programs and policies
  - a whole-of-government actuarial microsimulation model to identify priority cohorts, estimate the long-term fiscal and wellbeing impacts of prevention and early intervention, and monitor and evaluate interventions
  - a dedicated prevention and early intervention fund, supported by agreements with jurisdictions, for programs requiring joint investment from the Australian, state and territory governments.
- **An investment of $1.5 billion over five years could save governments $2.7 billion over ten years. When broader health, social and economic benefits are included, the net present value of total expected benefits would be around $5.4 billion over the same period.**
- **The PC recommends a staged implementation approach that would first build institutional capability for data, modelling and assessing interventions, set up a fund to support intergovernmental collaboration and then change funding arrangements to support sustained investment.**

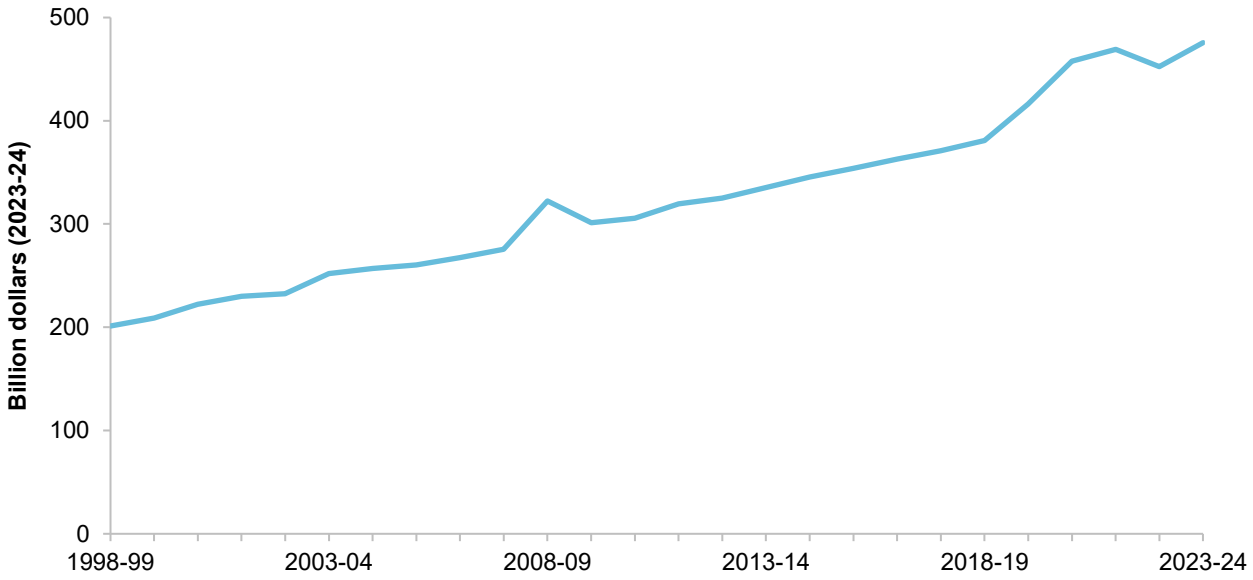
Investing in prevention and early intervention can improve outcomes and care sector efficiency

Future wellbeing and fiscal sustainability depend on today's prevention and early intervention efforts

Over the past 25 years, real spending on care and care-related expenses has increased by about 136% (figure 3.1), from $201.3 billion to $475.5 billion (PC estimates based on ABS GFS 2023-24). The *Intergenerational Report 2023* anticipates this trend will continue, with Australian Government spending on key areas of the care sector – health care, the National Disability Insurance Scheme, and aged care – projected to rise from 6.2% of GDP in 2022-23 to around 10.8% in 2062-63 (Commonwealth of Australia 2023, pp. 150–160).

Figure 3.1 – The upward trend of care and care-related expenses continues

Real care and care-related expenses for all levels of government from 1998 to 2024



Care and care-related expenses include social protection and total health expenses. All levels of government is an ABS classification which includes expenses of Australian, state and territory, and local governments.

Source: PC estimates using ABS (2025b, 2025a).

Government spending – driven largely by care-related expenditures – is expected to outpace government revenue, posing a major fiscal challenge (Commonwealth of Australia 2023). Without decisive action, future generations will face deeper health inequities and a care system increasingly unable to meet their needs. Governments face choices: they can pay for the additional costs by increasing taxes or copayments, or reduce costs by limiting access to care services. An alternative to these is to reduce future demand for services by investing today in evidence-based prevention and early intervention. Greater investment in prevention and early intervention can simultaneously improve outcomes and reduce costs, and represents an effective path for increasing productivity in the care sector.

Supporting such investment at adequate levels will involve significant change in how governments plan and allocate spending. But international and domestic examples indicate that a well-planned, incremental

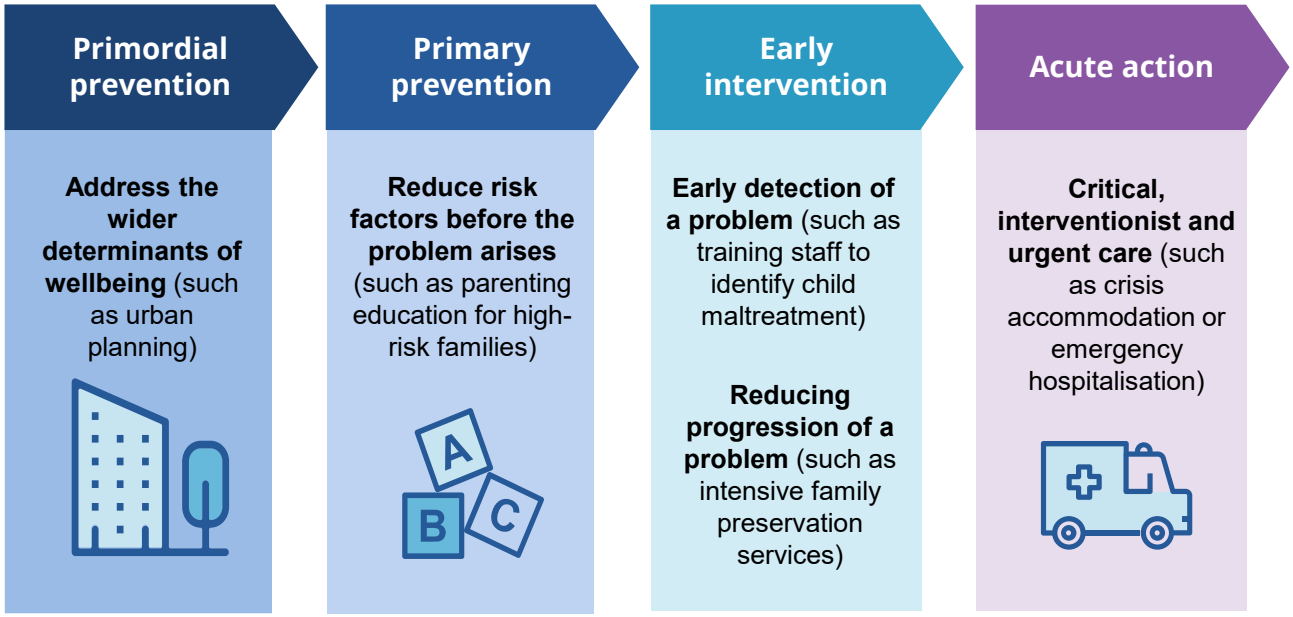
approach can achieve these aims. There is strong cross-sector support – from health, social services, and economic policy – for embedding a more systematic approach to prevention and early intervention into government decision-making. And the costs of inaction are high – poorer outcomes, greater pressures on the care system and rapidly rising care-related expenditure over the next few decades.

Prevention and early intervention reduce the risk of future problems or slow their development

Prevention and early intervention involve acting early to stop problems from starting or getting worse. Examples include promoting healthy lifestyles to prevent illness, supporting young people to stay out of the criminal justice system and helping people to avoid substance abuse. Prevention and early intervention are broader than population health, and include interventions in areas such as housing, education, justice and family support services, recognising that actions in one policy area may have benefits in others.

Prevention activities can address wider determinants of health and wellbeing including environmental, social and economic factors (primordial prevention). They can also reduce risk factors before problems arise (primary prevention). Early interventions can help detect issues early or slow the progression of a problem during initial stages[21] (figure 3.2). Acute or crisis services, on the other hand, respond to problems after they have intensified and require urgent actions that are often costly and can be associated with worse outcomes, such as treating people at emergency departments or detaining them in prisons.

Figure 3.2 – Prevention, early intervention and acute care lie on a spectrum



Some publications use the phrase ‘early interventions’ to refer to interventions targeted towards children and/or adolescents specifically. We take a broader definition and include interventions that are targeted towards adults, early in the stage of a problem’s development.

[21] While many sources refer to these as secondary or tertiary prevention, this report uses the term prevention to refer to primordial and primary prevention only.

Prevention and early intervention improve quality of care and lead to better outcomes

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

Programs in Australia and overseas have demonstrated that investment in prevention and early intervention has improved a range of individual outcomes. For example, programs have helped people at risk of homelessness achieve greater stability (Roggenbuck 2022, p. 1), reduced cancer rates and cancer-related deaths (Luo et al. 2019; Shih et al. 2017), reduced child maltreatment (Dalziel and Segal 2012; Quinlivan et al. 2003; Stout et al. 2022; WSIPP 2024a) and reduced risk factors for childhood obesity (Ananthapavan et al. 2020; Salmon et al. 2023).

Prevention and early intervention often produce benefits that spill over to the wider community through reduced future service and support needs, reduced crime, improved labour productivity, higher employment, and greater social cohesion. They can also address systemic inequities in care access and quality, as targeted programs can provide greater benefits to priority populations such as Aboriginal and Torres Strait Islander people (box 3.1), women or people of low socioeconomic status. For example, the Early Years Education Program led to improved IQ and language development among socially disadvantaged Australian children, with participants reaching developmental parity with peers within three years (Tseng et al. 2022, p. 5). Evaluations of similar initiatives in the United States, suggest that program benefits can persist well into adulthood and even intergenerationally (García et al. 2023) through improved lifetime education attainment (Campbell et al. 2012), employment and health, and reduced criminal behaviour (García et al. 2021, 2023).

Box 3.1 – Prevention and early intervention can 'accelerate improvements in the lives of Aboriginal and Torres Strait Islander people'[a]

Submissions to this inquiry reflect the importance of prevention and early intervention for Aboriginal and Torres Strait Islander people:

> prevention is fundamental to the Aboriginal and Torres Strait Islander concept of social and emotional wellbeing … It is about strengthening the cultural and social determinants of health. These are the protective factors that build resilience and create thriving communities. (Gayaa Dhuwi, sub. 167, p. 4)

However, submissions stressed the need for prevention and early intervention to be culturally safe, free from racism, and designed by and directed towards the needs of Aboriginal and Torres Strait Islander people (for example, IAHA, sub. 155, p. 5; RACGP, sub. 211, pp. 6,12; Tobacco Free Program, Yardhuna Walani, Australian National University, sub. 208, p. 6). Participants urged governments to consider the benefits of prevention and early intervention across the whole-of-government. For example:

> Action to improve housing conditions would see benefits for health and social outcomes, education and employment as well as mental health and wellbeing and could contribute to significant progress toward Closing the Gap targets. (NACCHO, sub. 21, p. 6)

Justice reinvestment and antenatal care are two examples of effective prevention and early intervention that can enhance the lives of Aboriginal and Torres Strait Islander people across wellbeing domains.

Box 3.1 – Prevention and early intervention can 'accelerate improvements in the lives of Aboriginal and Torres Strait Islander people'[a]

Supporting vulnerable youth

Justice reinvestment shifts spending from corrective services to place-based, community-led programs like family support, mental health and educational services for vulnerable youth at risk of incarceration.

Over one year in Bourke NSW:

- police-reported domestic violence **reduced by 23%**
- days spent in custody **declined by 42%**
- year 12 student retention **increased by 31%**.

Saving an estimated $3.1 million while incurring operational costs of $0.6 million.

Improving antenatal care

The Birthing in Our Community model (see box 2.2) provides comprehensive, culturally safe maternity care for mothers of Aboriginal and Torres Strait Islander background. It has outperformed standard care on multiple metrics and has been linked to:

- a **5.3 percentage point reduction** in preterm births
- **$4,810 in net savings** related to interventions in birth and neonatal admissions for each mother-child pair.

a. Clause 25 of the National Agreement on Closing the Gap.

Source: ALRC (2017); Gao et al. (2023); KPMG (2018, p. 22).

Prevention and early intervention can improve efficiency

In many cases, preventing a problem from developing is a more efficient use of resources than addressing it after it emerges. Prevention programs can deliver more value than their total cost (positive net benefits). They can reduce the need for higher cost acute and intensive services while achieving the same results (more cost-effective), and, in the best cases, can achieve better outcomes while reducing costs in the long run (cost-saving) (box 3.2, figure 3.3) (Vos et al. 2010; WSIPP 2024a). Directing resources to cost-saving prevention not only improves outcomes but also frees up funds for other uses, increasing the overall benefits for society from a given set of resources.

Box 3.2 – Efficiency, cost-benefit, cost-effectiveness, and savings

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

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

Box 3.2 – Efficiency, cost-benefit, cost-effectiveness, and savings

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

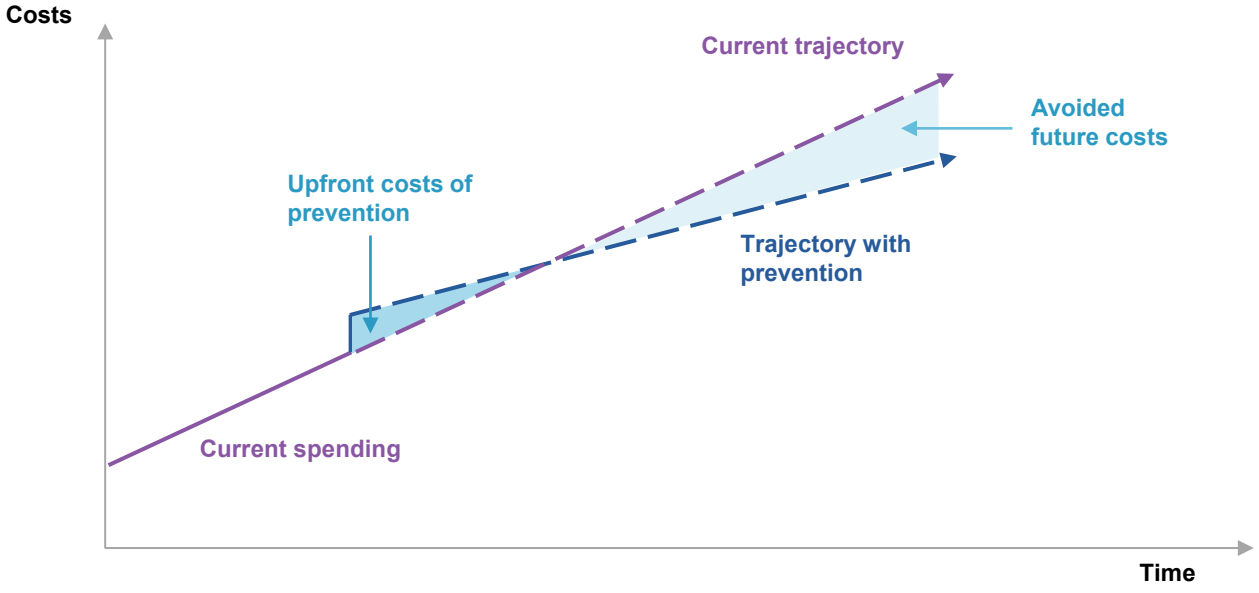
- cost-effective programs that achieve the desired outcome at an acceptable cost, even if it means spending more overall. Simply implementing a new cost-effective program might not save money but will still offer good value for the community. Replacing a less cost-effective program with a more cost-effective program can still lower overall spending
- cost-saving programs, that improve or maintain outcomes and reduce overall spending. Cost savings can happen at an individual level (where a person needs less care in the future) or system level (the government spends less overall on services and supports).

Cost-benefit analysis places a monetary value on all outcomes and inputs involved in a particular program (including non-monetary benefits) and tallies them up. This method is especially useful for valuing programs with broader effects across a range of outcomes. If a program's total benefits are greater than its costs, it is said to have a positive net benefit.

Distinguishing between savings and avoided costs

Prevention and early intervention programs can be expected to save money when they reduce overall demand for services (UK HM Treasury 2023). This will only occur without 'excess demand', where preventing one person's need for a service does not lead to another taking their place. Where demand for publicly-provided services exceeds supply – as is often the case with public hospital waiting lists – and access is managed by urgency of need, prevention may lead to future avoided treatment costs at an individual level. At a system-level, overall outcomes would improve, indicating an improvement in efficiency, although measurable savings may take longer to realise.

Figure 3.3 – Prevention and early intervention can alter the current trajectory of care costs



This figure is illustrative and does not use actual costs.

Numerous studies have demonstrated that well-designed prevention and early intervention programs can deliver substantial savings (figure 3.4). For example, most obesity prevention interventions assessed by Ananthapavan et al. (2020) were found to improve health outcomes while producing long-term savings. Moreover, the Australian *Assessing Cost-Effectiveness in Prevention* report identified a range of preventive interventions in health care that – for a total cost of $7.3 billion – delivered significant health gains and were estimated to generate $17.6 billion (2023-24 dollars) in avoided healthcare costs over the lifetime of the 2003 population (Vos et al. 2010, p. 47).

The development of data assets linking Australian Government and state and territory government data, coupled with machine learning and AI tools, could further increase gains from prevention and early intervention by enabling better targeting of priority cohorts (explored further below). In the United Kingdom, prediction tools have been used to identify elderly patients in community care at high risk of falls, leading to a 20% reduction in fall incidents, lowering hospitalisation numbers and costs while improving the quality of life of the people involved (Heger et al. 2024).

Figure 3.4 – Examples of cost-saving prevention and early intervention

Housing first approaches to homelessness

- Immediate, permanent housing with wrap-around supports
- Highly effective in helping participants sustain housing (66-90% success rate)
- In South Australia, the Aspire program was linked to avoided costs of **$8.9 million** over 4 years of implementation

Home-visiting program to reduce child maltreatment

- Australian home-visiting program for high-risk teenage mothers has been linked to reduced infant death, severe non-accidental injury of the infant and non-voluntary foster care
- Estimated to produce lifetime cost savings of **$295,000 per family**

Lifestyle intervention for gestational diabetes

- Preventing gestational diabetes with diet and physical activity interventions reduces ongoing risk of type-2 diabetes
- It is cost-saving over the lifetime of program participants, returning **$1.22** per dollar invested

The SunSmart campaign for skin cancer awareness

- Involves community programs and mass media campaigns
- Prevented 43,000+ skin cancers in Victoria between 1988 to 2010
- In Western Australia, the return to government was estimated to be **$8.70** per dollar invested

Source: Brown et al. (2024); Collins et al. (2024); Coram et al. (2022); Dalziel and Segal (2012); Lloyd et al. (2023); Quinlivan et al. (2003); Roggenbuck (2022); Shih et al. (2017).

The potential gains are large

Benefits from prevention and early intervention can be substantial, both for governments and the people that benefit directly. But they can accrue over a longer timeframe than governments usually budget for. For example, lifestyle interventions to prevent gestational diabetes can confer health benefits for women over the remainder of their life (Lloyd et al. 2023). The timeframe within which there is a return (the monetary value of the total net benefits relative to the cost of the intervention) on investment will depend on the intervention and the rate at which future benefits are 'discounted'.

Estimating the expected net benefits from a suite of prevention and early intervention actions is complex. It depends on the amount of investment, the expected return and the timeframe over which that return is

realised. For example, a bundle of evidence-based prevention and early intervention programs could be expected to return a net benefit to taxpayers after about five years. Spending $1 would be expected to return around $2.09 in fiscal benefits to the taxpayer within a 10-year period.[22] In addition, health, social and economic benefits worth $3.96 would accrue to participants and community.

There are persistent barriers to investment

Despite the benefits, governments tend to underinvest in early intervention and prevention, favouring care expenditure that may deliver more immediate returns. In health care alone, Australia ranked 27th out of the 36 OECD countries that reported their proportion of health spending on prevention in 2019 (OECD 2025). In 2019, Australia allocated 2% of health spending – roughly 0.2% of GDP – to prevention (OECD 2025).

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

Underinvestment in prevention and early intervention is commonly attributed to systematic issues in the way government agencies and departments work together to solve issues, allocate funding and measure the impact of policies.

- **Misalignment between who benefits and who funds**: Prevention and early intervention deliver cross-portfolio benefits but the agency and level of government that funds a program is not always the same as those that benefit (through future avoided costs). Budget processes rarely support collaboration, leading agencies to prioritise their own objectives and undervalue the shared gains of prevention (ANZSOG 2022, p. 5).
- **Short-term thinking**: Uncertainty and delayed returns over long timeframes often discourage governments from investing in prevention and early intervention. Unlike acute care, prevention and early intervention require upfront investment based on the expectation of long-term benefits that often manifest beyond the four-year budget cycle. While evaluations can help build confidence in specific interventions, they take time and resources.
- **Budgeting rules**: Budgeting rules can limit the ability of decision-makers to consider the flow-on effects of policy proposals including savings that accrue due to decreased demand for government services across different portfolios and savings that occur over longer timeframes. While Treasury and/or Finance could in principle consider these effects in decision-making, and have done so in limited circumstances, policy costings generally only consider the immediate direct effects of a policy change (box 3.3). Restrictions on including flow-on effects ensure that benefits that cannot be directly estimated are excluded from formal costings. However, inquiry participants have argued that increased recognition of flow-on effects of proposals across different portfolios and longer timeframes (especially when fiscal effects can be quantified with greater accuracy) would promote investment in prevention and early intervention.[23]
- **Evidence on effectiveness and long term benefits**: Inquiry participants reported that difficulties in accurately measuring and attributing the full economic and social value of prevention – and in particular, the extent to which prevention programs can deliver fiscal savings – leads to scepticism of the benefits of

[22] Details on these estimates are included in appendix B.

[23] More than 20 submissions argued for increased consideration of second-round effects including Ageing Australia (sub. 161, p. 14), AMA (sub. 94, p. 7) and Relationships Australia (sub. 65, pp. 24–25).

programs and presents a significant barrier to funding.[24] Multiple reports have recognised the need for more high-quality, publicly available evaluations (Ananthapavan et al. 2024, pp. 28–29; PC 2021, p. 29; Wise et al. 2005, p. 48) but such evaluations are difficult to conduct due to the lack of accessible high-quality data to track outcomes, the long timeframes that are needed to track outcomes and a lack of dedicated funding for evaluation (Francis and Smith 2015; Schwarzman et al. 2018). Even in cases where conclusive evidence exists, government agencies may lack the capacity and resources to understand and assess different approaches to prevention modelling, which reduces their influence on funding decisions (Ananthapavan et al. 2024, p. 31; Francis and Smith 2015).

Even when funding is allocated to early intervention and prevention, it is not always directed to programs that produce the greatest improvements in individual and societal outcomes – which can fuel scepticism. For example, government investment in drug and alcohol programs has not consistently aligned with evidence on what works (Alcohol and Drug Foundation 2019, p. 4; Newton and Lee 2019). In addition, obesity funding has been split across close to 200 programs of varying effectiveness (Tran et al. 2024), with only some producing substantial health and economic gains (Ananthapavan et al. 2020).

While many programs have been shown to deliver substantial benefits, the existence of ineffective programs can reinforce broader doubts about prevention and early intervention. These doubts can further grow when program proposals make claims of long-term benefits and savings that fail to materialise. The underlying challenge is not the availability of effective programs, but the absence of robust processes to support governments to systematically identify, evaluate and fund evidence-based interventions. Better processes for identifying evidence-based prevention and early interventions could also help identify existing spending or programs that are not delivering value for money.

Box 3.3 – Policy costings can undervalue prevention and early intervention

Policy costings are estimates of the expected impact of proposed policies on the Australian budget and are included in all budget proposals. But the approach to developing costings can systematically understate the benefits associated with prevention and early intervention, by focusing decision makers only on the direct effects within the four-year budget period and paying less attention to the longer-term, cross-portfolio 'flow-on' effects. Conceptually, the budget impacts of a policy proposal can be divided into three broad components:

- **Direct static impact** – all costing analyses contain a 'day after' impact, which assumes no change in behaviour by the affected groups. This includes the costs of providing a program, but ignores any changes in service demand
- **Direct behavioural impacts** – take account of changes in behaviour by individuals or organisations directly affected by a proposal and include the impacts on closely-related industries
- **Broader economic impacts** (also 'second-round' or 'flow-on' effects) – the broader impacts on 'the aggregate economy, or flow-on effects to other program outcomes' (Treasury and Finance 2024, p. 6) through changes in prices, wages, employment, the costs of care and the demand for other services, programs and government payments. These could include impacts occurring over long periods or affecting different portfolios or governments.

[24] More than 50 participants expressed this view including COSBOA (sub. 22, p. 9) and Silverchain (sub. 15, p. 6).

Box 3.3 – Policy costings can undervalue prevention and early intervention

Although potentially significant, flow-on effects can take a long time to manifest, can be difficult to estimate, may be subject to high levels of uncertainty and are more likely to be contested. As a result, there are fiscal risks of including them in the budget forward estimates. Longer term benefits are also affected by the rate at which they are discounted.[a]

The distinction between direct behavioural impact and flow-on effects can be unclear and may vary according to the stated goal of a policy. The ambiguity can lead to the exclusion of direct behavioural impacts as well as second-round effects from policy impact assessments, which in turn may prevent these impacts from being considered in the budget process (DSS, sub. 254, pp. 1-2).

The Budget Process Operational Rules (rules endorsed by Cabinet for managing Budget processes) and the Charter of Budget Honesty (guidelines for how election commitments should be costed) show that the flow-on effects are often excluded from policy costings and forward estimates:

> In almost all cases, only first round effects will be considered in costings. (Finance 2023, p. 16)

> Second-round effects are generally not included in costings for a range of reasons, including uncertainty in estimating the magnitude and timing of the effects and their net aggregate fiscal impact across Government systems. (Treasury and Finance 2024, p. 7)

While this approach manages fiscal risks, it affects the comparative assessment of longer-term initiatives that are likely to have effects across portfolios or governments. Without second-round impacts:

> the benefits of preventative initiatives are not correctly measured and the cost of reforms may be overstated … lead[ing] to less informed policy decisions and an under-investment in preventative measures, thereby leading to costly acute supports and interventions later (DSS, sub. 254, p. 2).

a. A higher discount rate places greater value on more immediate benefits by discounting the value of future benefits by a greater amount. The Australian Government's Office of Impact Analysis requires the calculation of net present values at an annual real discount rate of 7%, higher than the rate used for the Pharmaceutical Benefits Scheme (5%) and Medicare (5%), as well as the social policy discount rates used for cost-benefit analysis in NSW (5%) and Victoria (4%).

Source: PBO (2017), Finance (2023) and the Treasury and Department of Finance (2024).

These barriers have hampered current and past strategies to increase investment in prevention and early intervention.[25] The Victorian Early Intervention Investment Framework (box 3.4) shows a different and promising approach as it seeks to recognise the cross-portfolio benefits and long-term returns from prevention and early intervention. While there are legitimate concerns about including these benefits in the budget forward estimates, a robust framework and strong governance arrangements can still ensure these benefits are considered in decision-making processes, even if excluded from formal estimates.

We propose a new nation-wide approach to help overcome the structural impediments to funding for evidence-based prevention and early intervention initiatives.

[25] Examples include the National Partnership Agreement on Preventive Health (2008–2014), National Plan to Reduce Violence Against Women and their Children (2010–2022) and the National Preventive Health Strategy (2021–2030).

Box 3.4 – The Victorian Early Intervention Investment Framework

The Victorian Early Intervention Investment Framework is used to fund early intervention programs in education, social services, health and justice systems. Since its inception, funding has expanded from $324 million in 2021-22 (ANZSOG 2022, p. 19) to a budget commitment of $1.1 billion in 2024-25 (Victorian DTF 2024). Programs funded under the framework through the 2024-25 budget are estimated to generate total benefits of $1–1.3 billion over the next ten years, including $655–770 million from reduced government service use and $360–560 million in broader economic benefits such as reduced welfare payments (Victorian DTF 2024). The focus of the framework is on benefits for Victorian taxpayers.

Advantages of the framework

The framework's cross-portfolio approach streamlines funding proposal processes and improves inter-agency collaboration by considering benefits and savings across multiple portfolios. The framework also considers long-term priorities, requiring budget proposals to project program outcomes, costs and benefits over ten years. If a department runs a program that generates avoided costs for other departments, half of those savings are returned to it for reinvestment in early intervention. Returning half rather than the full avoided costs accounts for uncertainty in estimation of avoided costs and gives departments more flexibility to accommodate emerging needs. Repayment of these savings begins in the program's third year and is completed by the tenth year. Annual evaluation is compulsory, timely and consistent (Rose et al. 2023, p. 9,12). Funding is allocated based on benefit estimation modelling, evaluation and observed outcomes.

Questions around the framework remain

The robustness of the framework's cost-benefit analysis and evaluation is uncertain as modelling methodology and outcomes data are not made public. As the framework operates entirely within the Victorian Department of Treasury and Finance, its structure may create incentives that distorts decision-making. In particular, it may favour programs with higher estimated avoided costs over those demonstrating real effectiveness or delivering non-fiscal benefits. Programs that generate savings outside the portfolio are especially prone to overestimation, as limited accountability exists for verifying their claims. The inclusion of such savings in the budget forward estimates can also increase fiscal risks.

Increased transparency would allow greater confidence in the framework's longer-term effectiveness, particularly as five to six years of actual data now exists.

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

The way governments think about and invest in prevention and early intervention needs to change. The Australian Government should establish a National Prevention and Early Intervention Framework (the framework) to support government investment in programs that improve outcomes and reduce demand for future services. The framework seeks to reposition prevention and early intervention as strategic investments for governments. It is not defined by a single component but includes multiple reforms to governance, funding and policy assessment processes.

The framework takes an evidence-based approach and recognises the long-term and cross-portfolio benefits of prevention and early intervention programs. Decision-makers should be informed about both the direct and flow-on effects of a policy, including those that accrue to other sectors and over longer timeframes – particularly benefits that accrue due to changes in future 'downstream' service use. The framework provides policymakers with better estimates of these wider benefits to inform their decisions, but does not require these benefits to be included in budget forward estimates,[26] leaving that decision to the Australian Government Treasury and Department of Finance. This will minimise the fiscal risks associated with the framework – and, indeed, by providing extra rigour around assessment of program proposals, will substantially diminish the existing risks associated with prevention and early intervention programs.

The framework's consistent approach to assessing interventions would improve coordination and collaboration across portfolios and jurisdictions. It would give governments confidence that they are investing in effective programs.

The framework draws on lessons from established social investment models,[27] notably the Victorian Early Intervention Investment Framework, while introducing more transparent processes and additional fiscal safeguards. It shares some similarities with the Department of Social Services' Commonwealth Outcomes Fund but it adopts a broader cross-portfolio lens, expanding the scale of investment, strengthening the involvement of central agencies, and building capability within government to embed stronger valuation of prevention and early intervention into routine decision-making processes. Many features of the framework align with international examples of outcomes-based budgeting, which use actuarial microsimulation modelling to inform and prioritise budget allocations while accounting for the broader impacts of policies within the budget process (OECD/KIPF 2024).

The framework offers a practical way to put into operation the Australian Government's Measuring What Matters Framework.[28] By directing funding towards outcomes and tracking progress against them, it can embed Measuring What Matters within the policy process.

The framework would require governance reform, new funding arrangements and improved technical capability to support investment in prevention and early intervention. These elements would combine to enable a consistent and transparent process for identifying and recommending cost-effective prevention and early intervention programs and unlock potentially significant long-term benefits for the Australian community and government finances. Elements of the framework include:

- **an independent expert-led Prevention and Early Intervention Framework Advisory Board** (PEIFAB) to review and recommend proposed programs and validate estimates of cross-portfolio and long-term benefits
- **a prevention and early intervention assessment team** (the assessment team) to build government capability and support standardised and rigorous economic evaluation of prevention and early intervention programs, including through the use of an actuarial microsimulation model

[26] Official government four-year financial estimates used for budgeting.

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

[28] The Measuring What Matters Framework is a national wellbeing framework consisting of 50 indicators relating to health, security, sustainability, cohesiveness and prosperity (Treasury 2023).

- **a whole-of-population actuarial microsimulation model** to identify lifetime costs and priority cohorts, estimate the long-term fiscal and wellbeing impacts of interventions (including second-round effects), and monitor and evaluate interventions on an ongoing basis
- **a National Prevention and Early Intervention Investment Fund,** supported by agreements between Australian, state and territory governments to support jointly funded programs. In the longer term, this fund would be replaced by modifying existing sector-specific federation funding agreements to allocate a portion of their funding to jointly-funded programs.

A robust assessment and evaluation process to support confidence, consistency and rigour

A standardised process would ensure prevention and early intervention initiatives are assessed and evaluated with rigour and consistency (figure 3.5). This process would support consistent and transparent funding decisions, like the Medical Services Advisory Committee and Pharmaceutical Benefits Advisory Committee processes.[29] It would also serve as a guardrail to ensure that genuine and effective early interventions and prevention programs are funded, while filtering out programs that better fit into acute/crisis care, are ineffective, or offer lower value for money. This will be critical for building confidence in the approach.

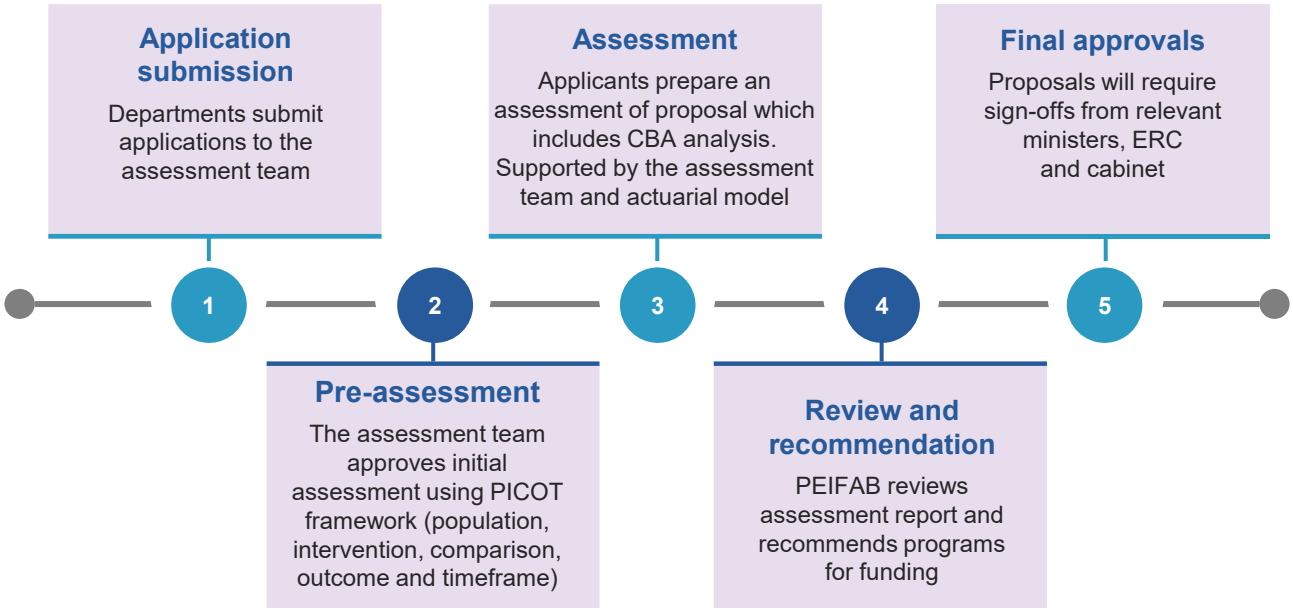
All Australian, state and territory government departments and agencies applying for funding through the framework should pass through the process, with variations in the final approval and funding stage depending on the source of funding.

- **Pre-assessment**: Australian, state and territory government agencies and departments submit a preassessment, to be approved by the assessment team established in Treasury. The preassessment should require identification of the intervention's target population, the main intervention being considered, an alternative intervention or control group that can be used as a comparator, expected outcomes due to the intervention, and the timeframe of expected effects. The preassessment would help ensure that proposals are in scope and suitable for review and funding through the framework.
- **Assessment**: Once the preassessment is verified, departments and agencies prepare a report addressing assessment criteria set out by PEIFAB, with support from the assessment team. The assessment report should include a review of the evidence for the proposed intervention, cost-benefit analysis (accounting for cross-portfolio and long-term benefits where appropriate) and equity analysis.
- **Independent review and recommendation**: PEIFAB reviews the assessment reports based on a prioritisation framework and recommends programs to relevant Ministers.
- **Approval and funding of proposals**: After PEIFAB's recommendation, final pathways for funding approval would depend on whether the program required federal investment alone or joint investment with state and territory governments (detailed later in the chapter). While all proposals seeking Australian Government funding would require approval from the Expenditure Review Committee and Cabinet, programs that also require joint contributions from state or territory governments would require agreement from relevant state and territory ministers. Any agreements specifying joint funding would follow approvals and outline each government's contribution based on expected benefit shares.

[29] For example, the Medical Services Advisory Committee is an independent body that assesses health services for inclusion in Australia's Medicare Benefits Schedule, ensuring they are clinically and economically effective. Its two-phase process follows a health technology assessment framework, beginning with preassessment and followed by detailed evaluation, committee review, and final recommendations to the Health Minister. While the committee's cost-effectiveness assessment is mainly based on health benefits and costs to the healthcare sector, costs to other sectors and broader economic benefits are sometimes considered in supplementary analyses. Outcomes are published in a public summary document.

- **Evaluation**: Regular evaluations of programs funded through the framework would enable potential improvements to be identified and ineffective programs defunded.[30] Evaluations could be run by departments and agencies with the support of the Australian Centre for Evaluation, consultants or academics. PEIFAB would recommend timelines for review and assess results from evaluations to advise governments on whether the program should receive ongoing funding, with this advice made public.

Figure 3.5 – Prevention and early intervention program approval process



What programs would be in scope?

Broadly speaking, the framework should support programs that improve care-related outcomes for individuals and the wider community, while at the same time allowing governments to reduce spending on future acute services. The framework should have a broad cross-portfolio scope – supporting prevention and early intervention across sectors such as health, aged care, housing, education, child protection and justice. Medical and pharmaceutical early interventions that are assessed by the Medical Services Advisory Committee and Pharmaceutical Benefits Advisory Committee would be out of scope.

Pilot trials aimed at generating new evidence should not be eligible for funding under the framework. Funding should be directed toward programs with a well-established evidence base.

While the framework is intended to eventually cover a wide range of policy contexts, governments may initially focus on one policy area, as a proof of concept, that has interventions backed by evidence of short- to medium-term payoffs. One example for early reform could be efforts to reduce the need for out-of-home care (OOHC) through family-preservation programs (box 3.5).

The framework could also ensure a focus on improving equity in existing priority areas,[31] including in the National Agreement on Closing the Gap, the National Plan to End Violence Against Women and Children

[30] A one-size-fits-all approach to evaluating programs is neither possible nor appropriate. Different methods of evaluation and evidence standards (including alternatives to randomised controlled trials) will be necessary in different circumstances including for smaller investments and programs with longer-term benefits.

[31] Recognised by over 30 participants including AHRC (sub. 235, p. 13), Seed Futures (sub. 170, p. 1) and WwWA, WWDA, AMWA, and NATSIWA (sub. 126, p. 17).

2022–2032, and Working for Women: A Strategy for Gender Equality. It could also direct efforts towards priority cohorts identified in the National Preventive Health Strategy 2021–2030 (DoH 2021c).

Box 3.5 – Example program: the value of preventing the need for out-of-home care

Out-of-home care (OOHC) is a temporary, medium- or long-term living arrangement for children who cannot live with their families. OOHC can significantly impact individuals and society (Doyle 2007). By preventing entry into OOHC, Australian governments can deliver better outcomes for children and reduce the need for future government interventions.

Children in OOHC often experience poor outcomes over the longer term. They are overrepresented in justice, health and social services, which incurs considerable personal and fiscal costs (Doyle 2007). OOHC is also associated with cycles of disadvantage: one study showed that 24% of children whose mothers had been in OOHC also enter care themselves (Lima et al. 2018).

Preventing the need for OOHC is of particular importance for the wellbeing of Aboriginal and Torres Strait Islander children who make up around 41% of children in OOHC (SCRGSP 2025b). The removal of Aboriginal and Torres Strait Islander children from their families contributes to worse outcomes in health, education, housing, employment and justice (AIHW 2018; ALRC 2017; Healing Foundation 2013). The continued overrepresentation of Aboriginal and Torres Strait Islander children in the child protection system stems from several historical, ongoing and interrelated factors, including intergenerational trauma arising from colonisation, systemic racism, inequality across social determinants of child wellbeing, and discriminatory laws, policies and practices (Darwin et al. 2023; QFCC 2021; SNAICC 2023). Efforts to prevent entry into OOHC are critical to ensuring governments meet their commitments under the National Agreement on Closing the Gap and reduce the number of Aboriginal and Torres Strait Islander children in OOHC. To be effective, prevention programs should enable self-determination through Aboriginal and Torres Strait Islander-led service provision and provide access to culturally-responsive secondary services (such as counselling) (Creamer et al. 2022; Darwin et al. 2023).

As of June 2023-24, more than 44,000 children were in OOHC, with total annual care services costing an average of $144,000 per child and up to $1.22 million in certain jurisdictions (SCRGSP 2025b). Costs per child have increased at an average annual rate of 7.7% in the past five years, with total costs at around $6.5 billion in 2023-24.

Evidence shows that family-preservation programs can reduce both entry and re-entry to care, improving outcomes for families and delivering near-term fiscal benefits. Modelling suggests these programs typically breakeven after five years and can have a benefit-cost ratio of approximately 1.9 within child-protection portfolios over ten years (SVA 2019).

The investment proposition strengthens when considered over longer timeframes and across portfolios and governments. State and territory governments make long-term savings through reduced need for healthcare, housing support, justice and next generation OOHC. The Australian Government saves on healthcare and income-support (NSW Stronger Communities Actuary 2022).

While the framework will focus on prevention and early intervention programs, it could also support assessments of broader policy initiatives such as taxes or regulation by applying elements like the actuarial model to estimate long-term, cross-portfolio benefits, followed by PEIFAB validation of those estimates.

Recommendation 3.1
Establish a National Prevention and Early Intervention Framework

The Australian Government should work with state and territory governments to establish a National Prevention and Early Intervention Framework. The framework would recognise prevention and early intervention as a strategic investment for governments and support them to invest in programs that improve outcomes and reduce demand for future acute and crisis care services.

Under the framework, a standardised review and recommendation process would assess governments' prevention and early intervention proposals and evaluate already funded programs by applying clear criteria regarding evidence, timescales, cross-portfolio benefits, equity effects and value for money.

The Australian Government Treasury should lead implementation of the framework, including by implementing recommendations 3.2 and 3.3. In partnership with state and territory governments, the Australian Government should progressively develop the capability, data assets and skills, as well as funding structures and processes, needed to embed investment in effective prevention and early intervention within the budget process.

Building blocks of the framework

Better valuation of prevention and early intervention in government funding processes

An expert-led board to provide independent advice

A Prevention and Early Intervention Framework Advisory Board (PEIFAB)[32] should be established to provide independent advice on proposals and to scrutinise and validate claims of their benefits. Such a board would provide confidence to decision-makers and the public on the effectiveness of spending. Its independence would add credibility to its assessment of proposals. PEIFAB should be federally funded and some of its functions should be based on the Medical Services Advisory Committee as well as international institutions that provide independent economic analysis of policies (for example, Netherland's Bureau for Economic Policy Analysis). The key functions of the board are as follows.

- **A standardised and transparent process to assess proposals and make recommendations**: To gain funding under the framework, all proposals would require a PEIFAB assessment and recommendation, with relevant ministers responsible for the final decision on funding through the budget process. PEIFAB's recommendations should be based on weighted assessment criteria (including strength of evidence, feasibility, equity effects and value for money (including long-term, cross-portfolio benefits).[33] Assessments of proposals should be released publicly to ensure transparency.
- **Validation of flow-on effects**: PEIFAB should verify estimates of the flow-on effects of prevention and early intervention proposals, particularly the projected long-term savings from reduced service demand

[32] PEIFAB is based on work done by Harris and Mortimer (2009) but has a broader, cross-portfolio focus that allows for consideration of programs and outcomes including and beyond the health sector.
[33] Over 50 participants emphasised including equity as a criterion including Dietitians Australia (sub. 140, p. 14), Grattan Institute (sub. 71, p. 4), HJA (sub. 86, p. 5) and Minderoo Foundation, Thrive by Five (sub. 145, p. 8).

across portfolios. This approach should encourage confidence and consistency in estimating the cross-portfolio and long-term benefits of prevention and early intervention, and help ensure they are considered in funding decisions.

- **Review programs for continued funding**: PEIFAB should regularly review programs funded through the framework, examining early indicators of change and the outcomes of evaluations. After reviewing evidence, PEIFAB should recommend whether programs should receive ongoing funding, be scaled up or down or defunded. It should also pass on advice for potential improvements to programs.
- **Cabinet submission advice:** At the request of Cabinet, the PEIFAB could provide independent, confidential advice on Cabinet submissions and specific budget bids identified as being for prevention or early intervention. This function would enable PEIFAB to advise on policy or regulation changes that do not require significant additional funding but may create 'downstream' savings for government.

PEIFAB's members should be subject matter experts from different social policy and care-related sectors, economists to verify cost-benefit analysis and actuaries to provide assessments of projected fiscal risks and impacts. Such a range of experts would be able to support a diversity of investment across cohorts, risk factors and sectors, while also balancing investments between short-term 'quick wins' and long-term high-rewards.

PEIFAB membership and processes should also engage relevant stakeholders and support shared decision-making with Aboriginal and Torres Strait Islander people (PC 2024d, p. 39). A cultural safety framework should set out how PEIFAB should partner with Aboriginal and Torres Strait Islander people and incorporate Aboriginal and Torres Strait Islander data and outcomes into the framework.

Inquiry participants strongly supported PEIFAB's proposed governance role and emphasised the need for institutional independence and the involvement of relevant stakeholders and diverse perspectives in membership and engagement. For example:

> The Prevention Framework Advisory Board (P[EI]FAB), with diverse representation in membership, should oversee portfolio composition, monitor balance, and recommend adjustments. The P[EI]FAB must be independent and not made reliant on any single term of government for continuation. (AMA, sub. 94, p. 7)

Further examples of the value participants placed on independence are included in the accompanying *What we heard* paper (PC 2025c).

Some participants suggested that the Australian Centre for Disease Control could perform a similar role to PEIFAB. However, the Centre lacks a focus on prevention beyond communicable diseases. If its remit were to be expanded, as has been proposed (Scamps 2025), the Australian Government could explore potential synergies between PEIFAB and the Centre for Disease Control.

An assessment team to support rigorous economic evaluation of prevention and early intervention

A prevention and early intervention assessment team should be established within the Treasury to support Australian, state and territory governments in producing standardised economic analysis of prevention and early intervention programs. The assessment team would be broadly similar to the idea of an Avoidable Cost Unit (Bowles et al. 2025) put forward by the Centre for Policy Development (sub. 244, pp. 8–9). The assessment team should:

- verify initial pre-assessment of prevention and early intervention proposals
- support departments and agencies to develop assessment reports for prevention and early intervention proposals according to PEIFAB's assessment criteria, and help improve program design if these criteria are not met

- manage the actuarial microsimulation model (see below) once it is developed and support its use to produce credible and standardised estimates of long-term and cross-portfolio benefits of prevention and early intervention.

The team should include staff experienced in benefit modelling and budget and Cabinet processes. Its place within Treasury would allow for a whole-of-government view, help build confidence in assessments and drive cultural change across government.

An actuarial microsimulation model to inform investment

The evidence and analytical base of the National Prevention and Early Intervention Framework should be underpinned by an actuarial microsimulation model that can predict how much individuals will use services in the future and assess the fiscal effect of investment proposals.

This model would use historical service-use data and population projections to forecast future outcomes. It would identify factors, such as life events or use of acute services, that affect people and expenses over time and calculate expected costs under scenarios, such as before and after preventive interventions.

The model should project lifetime government expenditure per individual across all major government service domains. It should also project social and wellbeing outcomes such as educational, housing and employment status that are aligned with the Measuring What Matters framework. In supporting different stages of program and policy development, the model can help to:

- identify target cohorts based on service use costs and/or poor outcomes
- estimate long-term fiscal and wellbeing impacts of interventions
- monitor and evaluate interventions going forward.

Such a model would provide a rigorous, systematic and widely accessible platform for the design and assessment of prevention and early intervention proposals.

Multiple inquiry participants recognised the opportunity from using an actuarial modelling approach to inform prevention and early intervention investments.[34]

The Australian Government currently lacks a comprehensive model to forecast individuals' service use and expenses, or a standardised model to assess the fiscal effects of social policy. However, actuarial microsimulation modelling is used as an input to some initiatives. For example, the Department of Social Services is using the Australian Priority Investment Approach to Welfare, Victoria has a Social Investment Model and New South Wales has its Forecasting Future Outcomes model. While these models provide a good analytical base, they lack a whole-of-government view and are not commonly incorporated into the decision-making process.

Combining existing actuarial modelling efforts

The Australian Government, in partnership with state and territory governments, should consolidate and combine existing data and modelling efforts, and invest in developing a whole-of-population, whole-of-government actuarial microsimulation model. Combining existing modelling efforts would avoid duplication, allow for a consistent methodology, and ensure the most effective use of scarce analytical resources. Funding could be sourced by redirecting existing departmental modelling resources into a consolidated national capability.

[34] This was suggested by over 15 participants including Diabetes Australia (sub. 164, p. 1), Taylor Fry (sub. 184, p. 4–6), and Sydney Policy Lab, The University of Sydney (sub. 76, p. 5).

State and territories' data is required to support the framework

Before developing a national model, administrative data from Australian, state and territory governments would need to be linked. This would enable coverage across different levels of government and across sectors such as health, social protection, education, justice, human services and housing. Current integrated resources, such as the Person Level Integrated Data Asset, the NSW Human Services Dataset and the Victorian Social Investment Integrated Data Resource, do not contain the requisite data to estimate benefits across all of government.

Existing efforts to integrate Australian, state and territory government data should be accelerated, with states and territories required to provide data as a condition of signing up to funding arrangements. Contributing states and territories should be able to access the microsimulation model to inform their own prevention strategies and budget processes, providing benefits to those jurisdictions.

Development should be incremental and overseen by an intergovernmental working group

The Australian Government Actuary, overseen by a working group consisting of Commonwealth, state and territory representatives with appropriate expertise, should develop the model. This would ensure rigour and national coordination, while embedding the perspectives of those who deliver prevention programs and bear a substantial share of their cost. The working group could draw on expertise from across the Australian government and other state modelling-focused teams for technical guidance, central agencies for budgetary alignment, and prevention experts to inform scenario modelling assumptions.

The model should initially project a limited set of outcomes (such as specific service use costs) and certain priority cohorts, then expand its scope over time to include additional outcomes and the broader population (Taylor Fry, sub. 184, p. 4). Since states and territories vary in their capability to use administrative data and actuarial modelling in policy development, the model could first integrate data from the Australian Government and select jurisdictions, with a view to eventually include all jurisdictions.

Once developed, the model should be managed by the assessment team within Treasury. Australian Government agencies and contributing jurisdictions should have access, with potential access for non-government entities considered in the medium term.

Recommendation 3.2
Ensure better evaluation of prevention and early intervention

As part of the proposed National Prevention and Early Intervention Framework, the Australian Government should embed better evaluation of prevention and early intervention into government funding processes by building capability in assessing the long-term and cross-portfolio impacts of proposals. The Government should:

- establish an independent Prevention and Early Intervention Framework Advisory Board that reviews and recommends proposed programs for funding and validates estimates of cross-portfolio and long-term benefits. The board should publish its advice on policy proposals
- create a prevention and early intervention assessment team within Treasury to build government capability and support the standardised economic assessment of preventive programs
- develop, in partnership with state and territory governments, a whole-of-government actuarial microsimulation model to identify target cohorts across the population and project expected lifetime government service expenditure and key wellbeing outcomes. The Australian Government Actuary should develop the model guided by an intergovernmental working group. Australian, state and territory governments should have access to the model to assess the whole-of-community costs and benefits of prevention and early intervention policies.

Collaboration between Australian, state and territory governments

The success of the framework will depend on developing collaborative relationships with state and territory governments and putting the infrastructure in place to support their engagement. The framework should facilitate intergovernmental collaboration in prevention and early intervention and establish a whole-of-government perspective on assessing and implementing programs.

A fund to support initial collaboration with states and territories

To support programs requiring joint investment with state and territory governments and to grow overall government investment in prevention and early intervention, the Australian Government should establish a National Prevention and Early Intervention Investment Fund, similar to the National Productivity Fund and the Commonwealth Outcomes Fund.

The fund would provide a pool of funding to support state and territory government bids for prevention and early intervention programs. These bids should initially be for programs that allow a gradual building of expertise within governments, including in the usage of the actuarial models, and the development of intermediate and longer-term indicators of program success.

The Australian Government should commit $1.5 billion over five years, with states and territories to add their own co-contributions for specific programs based on expected benefits. This is expected to support at least three or four bids each year and enable the framework to proceed carefully while expertise and capacity is developed across all levels of government. As the expertise and infrastructure to support prevention and early intervention investments develops and initial programs begin to show the value of prevention and early intervention, funding would be expected to grow. Returns to government will depend on the type and implementation of the programs funded. However, experiences from cost-saving prevention and early intervention programs in the United States suggest savings to government of around 2.1 times the initial, one-off investment could be expected over a ten-year period (appendix B).

An investment of $1.5 billion spread over five years could save government around $2.7 billion in the ten years after the initial investment. When the broader health, social and economic benefits are included with potential fiscal benefits the total benefits are likely to be about $5.4 billion, and will continue to accrue over time.[35] These estimates are more conservative than many of the examples raised in submissions, suggesting that potential benefits could be greater.[36]

Redirecting funding from existing budget items, especially those that are ineffective or duplicative, may offset some of the initial costs of greater investment in prevention and early intervention. But improving outcomes while limiting growth in future care expenditure will ultimately require new investment. Multiple submissions to this inquiry have stressed this point.[37]

[35] These estimates are on an investment of $300m each year for five years. The $2.7 billion in possible savings to government has a net present value of around $1.9 billion in current dollars. Total benefits are a net present value and have been calculated using a 7% discount rate. Further details on estimated benefits are in appendix B.

[36] Submissions and responses, including those by AHPA (qr. 76. p. 2), CCWA (sub. 198, p. 2), Each (qr. 37, p. 3), Playgroup Australia (qr. 22, p. 3), Queensland Health (sub. 116 p. 7), United Way Australia (qr. 58, p. 3) included a number of examples with greater returns.

[37] Submissions making this point include Carers Australia (sub. 143, p. 10), HCCWA (sub. 110, p. 6), Injury Matters (sub. 54, p. 5), MFC (sub. 73, p. 9) and Healthway (sub. 207, p. 6).

Ultimately, the amount to be spent under the framework would rely on funded programs demonstrating value. However, under the National Preventive Health Strategy, governments have committed to spending 5% of all health funding on prevention activity (around $8.9 billion per year in 2022-23). This fund would support progress towards meeting that target.

Funding schedules

Payments from the fund should be facilitated through federation funding agreement schedules,[38] which outline Australian Government payments and state or territory co-contributions based on expected benefit shares for each funding round. The funding schedules should also specify requirements for state and territory governments to report outcomes and savings, as well as maintain funding for existing effective programs. Funding schedules could also include conditional payments linked to pre-agreed outcomes.

An Intergovernmental agreement on the National Prevention and Early Intervention Framework

Australian, state and territory governments should agree on the objectives of the framework, institutional, governance and data sharing arrangements, and roles and responsibilities of different parties. This agreement would be similar in some ways to the intergovernmental agreement that underpins the revitalised National Competition Policy reforms.

This agreement would lay the foundations for joint investment by Australian state and territory governments in prevention and early intervention. It would not provide details of the exact financial contributions of signatories but would instead set up the necessary governance structures for implementation of the framework. The agreement would be accompanied by the funding schedules discussed above.

Amending sectoral federation funding agreements in the longer term

In the longer term, Australian Government funding for state and territory prevention and early intervention initiatives should be provided by modifying existing, sector-specific federation funding agreements (FFA). These FFAs – overarching agreements covering Health, Infrastructure, Environment, Education and Skills, and Affordable Housing, Community Services and Other sectors – enable the Australian Government to provide significant funding to state and territory governments for programs. FFAs should be adjusted to allocate a portion of funding to the framework on an ongoing basis, helping embed the framework into routine practice and expand its funding scale.

[38] Multilateral or bilateral Agreements between the Australian, state and territory governments for funding specific projects or programs.

Recommendation 3.3
Enable collaboration between Australian, state and territory governments

Recognising that the benefits and costs of effective prevention and early intervention often fall across different levels of government, the Australian Government should work with state and territory governments to address opportunities to fund programs through the proposed National Prevention and Early Intervention Framework (recommendation 3.1).

The Australian Government should lead work to establish a National Prevention and Early Intervention Fund to provide federal funding for state and territory-run programs requiring joint investment. The fund, which should be established within the Treasury portfolio, should involve a commitment of $1.5 billion over five years. States should co-fund programs based on their expected share of benefits, with these requirements outlined in federation funding agreement schedules.

Australian, state and territory governments should establish an intergovernmental agreement outlining the objectives of the framework, institutional, governance and data sharing arrangements, and roles and responsibilities of different parties.

In the longer term, the Australian Government should fund state and territory prevention and early intervention initiatives by modifying existing sector-specific federation funding agreements to allocate a portion of their funding to joint investments in prevention and early intervention on an ongoing basis. This approach would embed the framework into routine practice and expand its funding scale.

A staged approach to implementation

A staged approach to implementation (figure 3.6), led by the Australian Treasury, should begin with efforts to enhance data modelling and governance capability and new funding arrangements to support intergovernmental collaboration. This would be followed ultimately by changes to federation funding agreements to support the framework on a long-term basis. While full rollout may take time, the framework could start with one or two jurisdictions partnering with the Australian government on a single priority project to establish proof-of-concept. We would expect the initial priority project(s) to be funded in the 2027-28 budget. It could then expand to a small set of relatively high-reward and low-risk projects. Taking this gradual approach would build confidence in the potential of prevention and early intervention.

Figure 3.6 – Implementation plan over short, medium and long term

Actions	Lead[a]	Short term (2026 to 2027)	Mid term (2028 to 2030)	Longer term (2031 to 2032)
Set up data and modelling infrastructure to enable assessment and evaluation of prevention and early intervention				
Integrate administrative data from Australian, state and territory governments	Australian Government Actuary			
Develop actuarial microsimulation model to project selected service use costs for priority populations at the federal and state level	Australian Government Actuary			
Extend actuarial microsimulation model to whole-of-population and project lifetime government expenditure and key outcomes across major service domains	Australian Government Actuary			
Improve capability within government to assess prevention and early intervention				
Establish a prevention and early intervention assessment team within Treasury	Treasury			
Develop standardised guidelines for the cost-benefit analysis of prevention and early intervention	Prevention & early intervention assessment team			
Develop a cultural safety framework that sets out how agencies should partner with and incorporate Aboriginal and Torres Strait Islander data and outcomes	Treasury			
Set up Prevention and Early Intervention Framework Advisory Board and supporting frameworks				
Establish the Prevention Framework Advisory Board (PEIFAB) to develop framework and then commence reviewing proposals	Treasury			
Develop a prevention and early intervention prioritisation framework	PEIFAB			
Funding arrangements to support joint intergovernmental investment				
Develop and agree to an overarching intergovernmental agreement with states and territories	Treasury			
Establish a National Prevention and Early Intervention Fund for joint Commonwealth-state investments. Start with a few jurisdictions and high-return programs	Treasury			
Negotiate funding schedules to support payments from fund and determine state co-contribution requirements	Treasury			
Expand size of fund over time to include more jurisdictions and programs				
Modify existing FFAs to allocate a portion of funds to prevention and early intervention on an ongoing basis	Treasury			

While the figure lists a single lead agency for these steps, many of these actions will require engagement with other parts and levels of governments, as well as community and sector specific stakeholders.

Appendices

A. Public consultation

This appendix outlines the consultation process and lists the organisations and individuals who participated in the inquiry. The PC received the terms of reference for this inquiry on 13 December 2024. We held 111 meetings with 82 individual organisations (table A.1) and held three roundtables (table A.2). A consultation questionnaire was released on 19 May 2025 seeking feedback on specific aspects of our policy reform areas. The interim report was released on 13 August 2025, with feedback invited via a call for submissions. In total, 257 submissions (table A.3) and 96 questionnaire responses (table A.4) were received. Read submissions and questionnaire responses.

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

Table A.1 – Consultations

Participants
Aged Care Quality and Safety Commission (ACQSC)
Ageing Australia
Australian Council of Social Service (ACOSS)
Australian Council of Trade Unions (ACTU)
Australian Government Actuary
Australian Government Aged Care Quality and Safety Commission
Australian Government Attorney General's Department
Australian Government Department of Education
Australian Government Department of Finance
Australian Government Department of Health, Disability and Ageing
Australian Government Department of Social Services (DSS)
Australian Government Department of the Prime Minister and Cabinet (PM&C)
Australian Government Department of Veterans' Affairs (DVA)
Australian Government Treasury
Australian Healthcare & Hospitals Association (AHHA)
Australian Human Rights Commission (AHRC)
Australian Institute of Health and Welfare (AIHW)

Participants

Assoc. Prof. Ben Spies-Butcher (Macquarie University)
Better Health Network (BHN)
Boston Consulting Group (BCG)
Prof. Bruce Bonyhady (The University of Melbourne)
Burnet Institute
Business Council of Australia (BCA)
Care Economy CRC (CE CRC)
Central and Eastern Sydney Primary Health Network (CESPHN)
Centre for Policy Development (CPD)
Coalition of Aboriginal and Torres Strait Islander Peak Organisations (the Coalition of Peaks)
Dr David Cullen
Diabetes Australia
Disability Advocacy Network Australia (DANA)
e61
Eastern Melbourne Primary Health Network (EMPHN)
Financial Counselling Victoria (FCVic)
Assoc. Prof. Gareth Bryant (University of Sydney)
Gippsland Primary Health Network
Gold Coast Health
Grattan Institute
Health Services Union (HSU)
Holstep Health
HumanAbility
Inclusion Australia
Independent Health and Aged Care Pricing Authority (IHACPA)
Indigenous Allied Health Australia Ltd (IAHA)
Institute for Urban Indigenous Health
Interim First Nations Aged Care Commissioner
Jane Tiller (Monash University)
Prof. Mark Considine (The University of Melbourne)
McKinnon
Medical Software Industry Association (MSIA)
Murray Primary Health Network
Murrumbidgee Local Health District

Participants
National Aboriginal Community Controlled Health Organisation (NACCHO)
National Disability Services (NDS)
National Women's Alliances
NDIS Quality and Safeguards Commission (NDIS Commission)
New South Wales Health
New Zealand Social Investment Agency
Ngaweeyan Maar-oo
North Western Melbourne Primary Health Network (NWMPHN)
Northern Sydney Local Health District
Pathology Technology Australia
Primary Health Tasmania
Public Health Association of Australia (PHAA)
Queensland Health
Ralph Lattimore
Rebbeck
SA Ambulance
SEED Futures
Social Ventures Australia (SVA)
South Eastern Melbourne Primary Health Network (SEMPHN)
South Western Sydney Primary Health Network (SWSPHN)
Sydney North Health Network
Taylor Fry
The Front Project
The George Institute for Global Health
The Safer Air Project
Victorian Health Promotion Foundation (VicHealth)
Victorian Aboriginal Community Controlled Health Organisation (VACCHO)
Victorian Department of Treasury and Finance
WA Primary Health Alliance
Western Sydney Primary Health Network (WentWest)
Western Victoria Primary Health Network

Table A.2 – Roundtables

10 September 2025 – Collaborative commissioning roundtable
Participants
Adelaide Primary Health Network
Brisbane North Primary Health Network
Gold Coast Health
Hunter New England Local Health District
Metro North Hospital and Health Service
North Western Melbourne Primary Health Network
North Adelaide Local Health Network
Northern Sydney Local Health District
Northern Sydney Primary Health Network
Northern Territory Health

17 September 2025 – Regulation reform workshop
Participants
The Benevolent Society
Uniting NSW.ACT
Brotherhood of St. Laurence (BSL)
VIVA Mutual
SDN Children's Services
Life Without Barriers

30 September 2025 – Regulation reform roundtable
Participants
Ageing Australia
National Disability Services (NDS)
Council on the Ageing Australia (COTA)
People with Disability Australia (PWDA)
Private Healthcare Australia (PVA)
Australian Industry Group
UnitingCare Australia

Table A.3 – Submissions

Participants	Sub no.
Accenture	200
ACD	78
Adam Johnston	102
Adelina Tabila	40, 43
Advanced Pharmacy Australia (AdPha)	190
Aged Care Quality and Safety Commission (ACQSC)	256
Aged Care Research & Industry Innovation Australia (ARIIA)	122
Aged Care Workforce Remote Accord (Remote Accord)	109
Ageing Australia	20, 161
Alan Shiell	219
Alethux	226
Alliance 20 Quality and Safeguarding Peer Network (A20 Quality and Safeguarding Peer Network)	158
Allied Health Assistants' National Association (AHANA)	128
Amanda Stafford	39
ANDHealth	46
Anglicare Sydney	138
Attain Healthtech (Attain)	124
Australasian Institute of Digital Health (AIDH)	195
Australasian Society for Intellectual Disability (ASID)	58
Australian Academy of Science (AAS)	27, 233
Australian and New Zealand Society for Geriatric Medicine (ANZSGM)	90
Australian Association of Gerontology	134
Australian Catholic University (ACU)	193
Australian College of Nursing (ACN)	220
Australian College of Weight Management & Allied Health	47
Australian Commission on Safety and Quality in Health Care (ACSQHC)	29
Australian Council of Social Service (ACOSS)	14
Australian Council of Trade Unions (ACTU)	23
Australian Dairy Products Federation (ADPF)	17
Australian Digital Health Agency (ADHA)	176
Australian Health Promotion Association (AHPA)	125

Participants	Sub no.
Australian Healthcare and Hospitals Association (AHHA)	26
Australian Human Rights Commission (AHRC)	235
Australian Institute of Company Directors (AICD)	8, 228
Australian Institute of Health Innovation (AIHI)	249
Australian Institute of Refrigeration, Air Conditioning and Heating (AIRAH)	31, 148
Australian Medical Association (AMA)	94
Australian Multicultural Health Collaborative	156
Australian Nursing and Midwifery Federation (ANMF)	87
Australian Psychological Society (APS)	224
Australian Psychosocial Alliance (APA)	112
Australian Services Union (ASU)	6
Australian Small Business and Family Enterprise Ombudsman (ASBFEO)	231
AXiLe Informatics	229
Beyond Blue	162
Bolton Clarke	79
Brotherhood of St. Laurence (BSL)	180
Bupa Asia Pacific	10
Burnet Institute	144
Business Council of Australia (BCA)	7, 70
Business Council of Co-operatives & Mutuals (BCCM)	142
Cancer Council Australia	127
Cancer Council Western Australia (CCWA)	198
Care Economy CRC (CE CRC)	232
Carers Australia	143
Carers NSW	121
Carers Tasmania	92
Carla Treloar	236
Catholic Health Australia (CHA)	165
Centre for Community Child Health, Murdoch Children's Research Institute (CCCH)	201
Centre for Digital Transformation of Health (CDTH)	135
Centre for Policy Development (CPD)	33, 244
Chamber of Commerce and Industry Western Australia (CCIWA)	13
CheckUP Australia	150

Participants	Sub no.
Children's Cancer Institute (CCI)	51
Churches of Christ Life Care Ltd (Life Care)	77
Cleaner Air Collective	113
Committee for Sydney	152
Commonwealth Bank of Australia (CBA)	24
Community and Public Sector Union (PSU Group) (CPSU)	75
Community Flower Studio	1
Community Mental Health Australia (CMHA)	159
Complementary Medicines Australia (CMA)	151
Consumer Healthcare Products Australia (CHP Australia)	252
Council of Small Business Organisations of Australia (COSBOA)	22, 197
Creative Australia	257
Crohn's & Colitis Australia (CCA)	67
Dairy Australia	234
David Lee	42
Deafness Forum Australia	52
Deakin Health Economics, Deakin University (DHE)	61
Dementia Australia	2
Department of Social Services (DSS)	254
Diabetes Australia	164
Diabetes Victoria	132
Dietitians Australia	140
Digital Health Cooperative Research Centre (DHCRC)	247
Disability Employment Australia (DEA)	157
Emerge Women and Children's Support Network	168
Employee Ownership Australia (EOA)	41
Eolas Medical	59
Ethnic Communities Council of Queensland (ECCQ)	55
Exercise and Sports Science Australia (ESSA)	119
EY Australia	147
Financial Counselling Victoria (FCVic)	64
Food for Health Alliance	141
Fortinet	227

Participants	Sub no.
Frances Barraclough	63
Friends of Really Excellent Dentistry (FRED)	98
Future Smart Strategies	50
Gayaa Dhuwi (Proud Spirit) Australia (Gayaa Dhuwi)	167
GlaxoSmithKline Australia (GSK)	139
Grattan Institute	71
Group of Eight (Go8)	30
HammondCare	133
Health Consumers' Council WA (HCCWA)	110
Health Economics and Policy Evaluation Research (HEPER) group, Centre for Medicine Use and Safety, Faculty of Pharmacy and Pharmaceutical Sciences, Monash University (HEPER group, Faculty of Pharmacy and Pharmaceutical Sciences, Monash University)	174
Health Economics Collaboration	250
Health Economics Group, School of Public Health and Preventive Medicine, Monash University (HEG)	243
Health Justice Australia (HJA)	86
HealthWISE	111
HMS Community Homecare and Clinic	81
HumanAbility	3, 191
Impact Obesity and Australian and New Zealand Metabolic and Obesity Surgery Society (Impact Obesity and ANZMOSS)	82
Inclusion Australia	117
Independent Schools Australia (ISA)	255
Indigenous Allied Health Australia Ltd (IAHA)	155
Infrastructure Victoria	89
Injury Matters	54
Insurance Council of Australia (ICA)	106
IQVIA Australia	85
James Trevelyan	44
JFA Purple Orange	237
Joan Ozanne-Smith	146
Kernl	185
KPMG Australia	25, 115
KU Children's Services	196
La Trobe University	216

Participants	Sub no.
Lite n Easy	4
Logan Child Friendly Community Limited (Logan Together)	136
Lung Foundation Australia	120
M2M North Shore	57
Mallee Family Care (MFC)	73
Massage & Myotherapy Australia	11, 91
Max Vardanega	242
Medibank Private (Medibank)	137
Medical Software Industry Association (MSIA)	213
Medical Technology Association of Australia (MTAA)	212
Medicines Australia	248
Melbourne Disability Institute, Australian Welfare and Work Lab - University of Melbourne	107
Members Health Fund Alliance (Members Health)	214
Mental Health Victoria	253
Michele Lemmens	187
Microsoft	230
Military and Emergency Services Health Australia (MESHA)	99
Minderoo Foundation, Thrive by Five	145
Mission Australia	153
Murrumbidgee Local Health District and Murrumbidgee Primary Health Network (MLHD/MPHN)	240
MYSKILLSmanager	192
Natalie Winter	189
National Aboriginal Community Controlled Health Organisation (NACCHO)	32, 215
National Disability Services (NDS)	241
National Eating Disorders Collaboration (NEDC)	66
National Growth Areas Alliance (NGAA)	222
National Rural Health Alliance (NRHA)	178
NDIS Quality and Safeguards Commission (NDIS Commission)	258
NewDirection Care	9
NSW Council of Social Service & Australian Council of Social Service (NCOSS & ACOSS)	169
Palliative Care Australia	72
Penelope and Ben Clark	101
People with Disability Australia (PWDA)	93
Pfizer Australia and New Zealand	194

Participants	Sub no.
Planetary Health Equity Hothouse (ANU)	118
Playgroup Australia	96
PHN Cooperative	104
Private Healthcare Australia (PHA)	18
Proactive Ageing Pty Ltd	38
Public Health Association of Australia (PHAA)	16, 97
Public Health Genomics, Monash University	246
Quality for Outcomes (QfO)	62
Queensland Alliance for Mental Health (QAMH)	172
Queensland Health	116
Queenslanders With Disability Network (QDN)	149
Raymond Bange	160
Redkite	130
Regional Australia Institute (RAI)	5, 223
Relationships Australia	65
Research Australia	202, 203, 205
Roche Products	183
Royal Australasian College of Physicians (RACP)	69
Royal Australian College of General Practitioners (RACGP)	28, 211
Sarah Moon	80
Scalable Health Intervention Evaluation program, University of Melbourne (SHINE)	56
Science & Technology Australia	225
SEED Futures	170
Seer Data & Analytics	53
Services for Australian Rural and Remote Allied Health (SARRAH)	177
Shona Bates	45
Silverchain Group (Silverchain)	15, 204
Social Ventures Australia (SVA)	163
Speech Pathology Australia	173
St Luke's Medical and Hospital Benefits Association Ltd (St Lukes Health)	238
Stephen Carbone	166
Stephen Duckett	35

Participants	Sub no.
Streets People Love Hobart Inc (SPLH)	95
Stroke Foundation	182
Susan J. Méndez, Jongsay Yong and Yuting Zhang, Melbourne Institute of Applied Economic and Social Research, University of Melbourne (Melbourne Institute, University of Melbourne)	100
Sydney Policy Lab, The University of Sydney	76
Tan Nguyen	68
Taylor Fry	184
The Australian Prevention Partnership Centre (Prevention Centre)	129
The Centre for Future Work at the Australia Institute	12
The George Institute for Global Health	154
The Health Alliance (a joint initiative of Metro North Health and Brisbane North PHN) (The Health Alliance)	84
The Pharmacy Guild of Australia	21
The Prevention Research Collaboration and The Charles Perkins Centre, The University of Sydney	239
The Public Good	60
The Safer Air Project	131
Thomas Haskell	83
Thriving Queensland Kids Partnership, ARACY (TQKP)	34
Tobacco Free Program, Yardhura Walani, National Centre for Aboriginal and Torres Strait Islander Wellbeing Research, The Australian National University (Tobacco Free Program, Yardhura Walani, Australian National University)	208
UNICEF Australia	74
United Workers Union (UWU)	199
Uniting NSW.ACT	114
UnitingCare Australia	123
Universities Australia (UA)	186
University of New South Wales (UNSW)	251
UNSW Ageing Futures Institute	108
Valeriy Ogienko	36
Victorian Disability Worker Commission (VDWC)	175
Victorian Health Promotion Foundation (VicHealth)	19, 103
Victorian Healthcare Association	245
Volunteering Australia	171
Wellbeing and Prevention Coalition in Mental Health	105

Participants	Sub no.
Wes Morris	179, 217, 218
Western Australian AI Hub (WA AI Hub)	221
Western Australian Health Promotion Foundation (Healthway)	207
Women With Disabilities Australia (WWDA)	188
Working with Women Alliance, Women With Disabilities Australia, Australian Multicultural Women's Alliance, and National Aboriginal and Torres Strait Islander Women's Alliance (WwWA, WWDA, AMWA, and NATSIWA)	126
Young People In Nursing Home National Alliance (YPINH National Alliance)	206
Anonymous	37
Anonymous	48
Anonymous	49
Anonymous	88
Anonymous	181
Anonymous	210

Table A.4 – Questionnaire responses

Participants	qr no.
Advanced Pharmacy Australia (AdPha)	60
Anita Franklin	4
Australian Catholic University (ACU)	40
Australian Health Promotion Association (AHPA)	76
Australian Industry Group (Ai Group)	50
Belinda	7
Bronwen Mary Dalton	19
Business Council of Co-operatives and Mutuals (BCCM)	52
Cancer Council Australia	28
Care Economy CRC (CE CRC)	51
Carers NSW	78
Caroline Robinson	75
Catholic Health Australia (CHA)	65

Participants	qr no.
Centre for Community Child Health, Murdoch Children's Research Institute (CCCH)	93
Centre for Policy Development (CPD)	96
Co-Chairs Prof. Alta Schutte and Prof. Markus Schlaich, on behalf of the National Hypertension Taskforce	42
Community Council for Australia (CCA)	32
Deafness Forum Australia	34
Deakin University's Faculty of Health; Institute for Physical Activity and Nutrition (IPAN); Institute for Health Transformation (IHT); SEED Centre for Lifespan Research	69
Dental Health Services Victoria (DHSV)	38
Diabetes Australia	45
Each	37
Fixing the NDIS research team, Centre for Disability Research and Policy, The University of Sydney	31
Flinders University	87
Gotcha4Life Foundation	21
Grattan Institute	56
GSK Australia	66
Harbison Residential Care Limited t/as Harbison	43
Health Consumers' Council WA	48
Injury Matters	20
International Centre for Future Health Systems & Centre for Social Research in Health UNSW	23
Jaithri Ananthapavan	33
Kaarin Jane Anstey	94
Lauren Hutton	5
Liz Keen	13
Margo Linn Barr	35
Medical Software Industry Association (MSIA)	77
Medical Technology Association of Australia (MTAA)	47, 63
Medicines Australia	81
Minda Incorporated	8
Mission Australia	62
Montu Group Pty Ltd	84
Mudgee Region Health Alliance	83
Municipal Association of Victoria (MAV)	44
Murrumbidgee Primary Health Network (MPHN)	89
National Centre of Excellence in Intellectual Disability Health (NCEIDH)	80

Participants	qr no.
National Disability Services (NDS)	85
National Eating Disorders Collaboration (NEDC)	54
National Rural Health Alliance	97
Novo Nordisk (Oceania)	55
Pfizer Australia	71
Playgroup Australia	22
Rebecca Cannon	30
Rehabilitation Medicine Society of Australia and New Zealand (RMSANZ)	82
Royal Australasian College of Physicians (RACP)	64
Scleroderma Australia	67
Scope (Aust) Ltd	27
Stella Perkins	16
Dr Stephen Alomes	59
Susan Mendez	36
Sydney Policy Lab at the University of Sydney	61
The Australian Prevention Partnership Centre	86
The Benevolent Society	73
The George Institute for Global Health	68
The George Institute for Global Health and The Leeder Centre for Health Policy, Economics and Data	72
The Health Alliance, a joint initiative of Metro North Health and Brisbane North PHN (The Health Alliance)	70
The Retirement Living Council (RLC)	98
The Safer Air Project	57
The Salvation Army Australia	24
The Tech Council of Australia (TCA)	88
United Way Australia	58
Uniting Church in Australia Queensland Synod	26
Uniting NSW.ACT	53
UnitingCare Australia	95
Dr Vicki Brown	39
Vicki Winfield	14
Victoria Department of Health	46
Wellbeing and Prevention Coalition in Mental Health	74
Wes Morris	91
Working with Women Alliance, Australian Multicultural Women's Alliance (WwWA and AMWA)	92

Participants	qr no.
Anonymous	1
Anonymous	2
Anonymous	3
Anonymous	6
Anonymous	9
Anonymous	10
Anonymous	11
Anonymous	12
Anonymous	15
Anonymous	17
Anonymous	25
Anonymous	29
Anonymous	41
Anonymous	79
Anonymous	90

B. Technical appendix

This appendix provides information on how we calculated the benefits of reforms recommended in the inquiry into *Delivering quality care more efficiently*.

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

Our approach

Chapter 1 of this report makes recommendations to align quality and safety regulation across the care economy, initially commencing with aged care, the National Disability Insurance Scheme (NDIS) and veterans' care, and in some instances, early childhood education and care (ECEC). Here, we outline the modelling approach and key assumptions used to estimate the benefits arising from the regulatory reforms proposed in that chapter.

The objective of the modelling is to provide insight into the expected savings resulting from the proposed reforms. Estimates are based on evidence -informed assumptions and should be interpreted as indicative rather than precise point estimates. Modelling has focused on direct, quantifiable savings to providers and workers, and does not attempt to capture quality improvements, service accessibility gains, or long-term productivity effects that may also result from reform. Specifically, we have modelled the benefits of the following recommendations:

- in relation to workers – a national worker screening check (part of recommendation 1.1)
- in relation to providers – aligning provider suitability tests and audit and registration requirements (part of recommendation 1.2).

Other recommendations were not modelled because sufficient data to estimate the proposed reforms was not available.

Methodology and data sources

The direct benefits of the regulatory reforms for workers and providers were calculated by estimating the time and cost savings of individual reforms and representing these in dollar terms. This approach directly links the estimated benefits to the change resulting from reforms. The following steps were taken to estimate benefits for both the provider- and worker-related reforms.

1. **Identify the quantifiable reforms:** identify activities that would be impacted by reforms and are quantifiable with available data.
2. **Define the target population:** identify the number of providers or workers affected by the regulation or reform annually across the care sectors in scope.
3. **Define the base case:** identify the current compliance activities being undertaken that would be reduced by the reforms.

4. **Identify changes under the reforms:** specify how the regulatory compliance activities would change under the proposed reform (for example, reduced frequency).
5. **Estimate the unit cost per activity:** quantify the cost of each activity, including time, labour and fees.
6. **Identify expected growth to relevant components:** apply growth rates to unit costs, and the number of providers and workers.
7. **Calculate the total effect:** estimate total benefits as the *change in activity* × *unit cost* × *number of affected entities* × *growth rates*. Total effects are discounted to 2025 dollars where relevant.
8. **Calculate equivalent care hours:** divide the total effect by the average care worker wage plus overhead costs.

Table B.1 shows the application of these eight steps to the proposed reforms. Table B.2 outlines the assumptions used as inputs to estimate the benefits.

Table B.1 – Benefit estimation approaches

Step	Worker-related reforms (recommendation 1.1)	Provider-related reforms (recommendation 1.2)
1. Quantifiable reforms	National worker screening check.	• Common suitability test. • Cross sectoral registration and audits.
2. Target population	Workers currently required to hold both an NDIS worker screening check and a working with children check (WWCC) or working with vulnerable people check.	Providers operating in two or more of the NDIS, aged care and veterans' care sectors (and ECEC for suitability tests).
3. Base case	Workers currently complete two screening checks.	Every three years, providers undertake registration, auditing, and suitability activities for each sector of operation. NDIS providers also undertake a mid-term audit at 18 months after registration (or renewal).
4. Reform change	Reduction from two to one screening check per worker.	Consolidation from multiple regulatory activities into a single, cross-sector process.
5. Cost per activity	Activity cost = (worker time × wage rate) + screening check fee.	Activity cost = (staff time × wage rate) + regulatory fees.
6. Growth	• NDIS workers grow by expected NDIS participant growth of 4.4%. • Wage rate and screening fees grow by 3.5%, as per wage price index.	• Providers grow by 5% as per PC assumption based on predicted NDIS and aged care provider growth. • Wage rate and regulatory fees grow by 3.5%, as per wage price index.
7. Total benefit	Workers × change in screening requirements × activity cost × growth.	Providers × change in activity × activity cost × growth.
8. Equivalent care hours	Total benefit ÷ (average wage of care workers x overhead multiplier).	

Table B.2 – Model inputs

Parameter	Value	Rationale	Source
Start year	2034	Year reforms assumed to be fully implemented.	PC's proposed reform implementation plan
Modelling horizon	10 years	Aligns with: • standard approaches for similar modelling exercises • regulatory burden measurement framework guidance on costing annual impact for policy proposals.	OIA (2024)
Price base year	2025	Benefits discounted to current year.	-
Discount rate	7%	Discount rate required by the Office of Impact Analysis (OIA) for cost–benefit analyses. Sensitivity testing conducted at 3% and 10%.	ACE (2025)
Inflation	3.5%	Percentage increase in total hourly wages in the health and social services sector between June 2024 and June 2025.	ABS (2025f)
Average wage (with overheads)	$79.60	Salary assumption underpinning the impact analysis for the Aged Care Bill 2024.	DoHAC (2024)
Average sector wage (without overheads)	$41.54	Average wage across the health and social care assistance sector. We assume that most workers in the care sector are required to undertake WWCCs. This variable is applied when overheads should not be included, such as when calculating the wage value of saved worker time.	ABS (2024)
Average frontline staff wage (without overheads)	$28.96	Hourly wage of a full-time level 4 aged care worker, representing the average frontline care worker.	FWO (2025)
Provider growth	5.0%	PC assumption informed by forecast growth in the number of NDIS and aged care providers (NDIS Quality and Safeguards Commission 2025c; ACQSC, pers. comm., 27 October 2025).	PC assumption
Provider time per audit cycle	155 hours	Based on average end-to-end audit time for category four and five aged care providers. We have used this parameter to represent the time taken for suitability checks, registration and audit processes, since these activities are intertwined within the regulatory compliance cycle.	DoHAC (2024)
Fees paid by providers per audit cycle	$35,655	Based on a weighted average of cost recovery fees according to the typical service profile of	PC estimate based on ACQSC (2025a) and data provided

Parameter	Value	Rationale	Source
		aged care providers in the target group, and the audit fee provided by an NDIS provider.	by an NDIS provider (pers. comm., 26 September 2025).
NDIS workers	1,354,714	Count of individuals who have submitted an NDIS worker screening check application to a state or territory worker screening unit since February 2021 (when checks were made mandatory), as at June 2025.	NDIS Quality and Safeguards Commission (2025c)
Proportion of NDIS workers requiring working with children check	52.9%	PC assumption based on the proportion of active NDIS participants who were under 18 years of age at the end of Q4 2024–25 (NDIA 2025a). We assume that the proportion of NDIS workers that work with children is commensurate with the proportion of NDIS participants under 18.	PC assumption
Screening frequency	Every five years	PC assumption based on length of validity of worker screening checks. NDIS and aged care worker screening checks are valid for up to five years (NDIS Quality and Safeguards Commission 2025d), while WWCCs are valid for two, three, or five years depending on jurisdiction (NT Police, Fire & Emergency Services 2025; Service NSW 2025; WA DoE 2025). The assumption is therefore conservative.	PC assumption
Worker screening fee	$133	Estimated average fee derived from state and territory WWCC and NDIS worker screening fees, weighted by state populations.	PC estimate derived from government websites and ABS population data (ABS 2025c)
Worker time per screening	1.5 hours	PC assumption informed by the Department of Finance's modelling (pers. comm., 21 October 2025).	PC assumption
NDIS worker growth	4.4%	PC assumption based on projected annualised percentage growth in NDIS participants (NDIA 2024a). Worker growth rate projections were unavailable; growth in NDIS participants was therefore used as a proxy.	PC assumption
Overhead multiplier	1.75	Established OIA methodology for scaling wages to account for the non-wage labour on-costs and overhead costs.	OIA (2024)
Female share of paid care workforce	75%	Aligns with national labour statistics.	Jobs and Skills Australia (2025)

Assumptions and limitations

The modelling makes the following assumptions.

- The timing and cost of veterans' care regulatory activities are treated as equivalent to aged care services. This assumption has been made due to limited data on the costs associated with complying with veterans' care requirements.
- All aged care providers in the target group are assumed to be registered in category four or above, to simplify cost assumptions.[39] While this may overestimate cost savings, providers operating across multiple care sectors tend to be larger meaning they may be more likely to conduct category four and above care activities.
- Provider audit and registration fees are based on a weighted average of aged care and NDIS audit fees to ensure consistency, given the limited data on actual NDIS audit fees.
- Veterans' care and aged care workers are excluded from worker screening check estimates as they are assumed not to work with children and therefore not require multiple screening checks.
- All providers in the target group face the same costs for regulatory compliance activities. This approach is used to simplify calculations and reflects the limited availability of more detailed data. This issue is particularly relevant in the NDIS sector, where public information regarding auditing fees is currently limited. As a result, variations among providers are not represented.
- There are no behavioural changes or additional market entry beyond normal provider growth, assumed to be 5% per year.
- The proportion of NDIS participants aged 18 years and under remains constant at 53% (i.e. no growth). While the current portion of new participants aged 18 and under is higher than this, the recent announcement of Thriving Kids may affect the number of children entering the NDIS in future. While we are unsure of the magnitude of this change, we expect it to slow growth in new NDIS participants who are children and as such have made a conservative estimate of no future growth in the proportion of young people aged 18 years and under.
- The proportion of the NDIS workforce requiring a national screening check does not consider worker churn. The estimates assume the stock of NDIS workers grows at 4.4% each year with a fixed proportion needing a WWCC every five years. It does not make any assumptions regarding the proportion of the growth in NDIS workers who will also require a check upon commencement as an NDIS worker.
- The status quo policy environment remains consistent over the estimated timeframe and therefore only includes benefits for currently registered providers. Any future changes that would require more workers and providers to become registered would likely result in additional savings.

The modelling includes the following limitations.

- The analysis is limited to quantifiable compliance cost savings. It does not capture broader effects such as quality improvements, consumer welfare gains, or efficiency changes within care sectors.
- Implementation and transition costs are excluded, including one-off costs associated with system integration, staff training or IT upgrades.
- The benefits relate to time savings and direct cost savings from fewer fees associated with worker checks and provider suitability, registrations and audits only. There may be other benefits, such as reduced processing times or staff training requirements that have not been included due to lack of data to inform assumptions.

[39] All providers of funded aged care services that receive Australian Government funding must be registered in one or more provider registration categories. The categories are based on the types of services delivered. Categories four, five and six cover more intensive services like personal care and support services, nursing and transition care and residential care services (ACQSC 2025b).

- Estimates are based on average unit costs and proxy data where detailed sector-level information was unavailable. Differences across provider size, region, and sector are therefore not fully reflected.

The Department of Finance's estimates of the benefits of a national worker screening differ to the PC's due to differences in the scope of the policy recommendation being measured. Despite these differences, both approaches demonstrate the significant cost savings that will accrue to workers from reduced application and compliance costs. In addition, the Department of Finance estimates that improved identity verification processes (which have not been included in the PC's analysis) would reduce compliance burdens by $122 million annually. Similarly, the Department of Finance estimates that reduced delays from automating the screening process for simple cases (which have not been included in the PC's analysis) would deliver a potential national benefit of $143 million annually from commencement (Commonwealth of Australia 2025, p. 13).

Results and sensitivity tests

Tables B.3-B.6 summarise the modelling results and sensitivity analyses. Table B.3 shows the annual benefits by recommendation, with nominal amounts adjusted to both 2024-25 dollars and discounted at 7% according to OIA guidance. Table B.4 shows the breakdown of benefits by different types of savings. Table B.5 indicates how much total nominal benefits change when each variable shifts up or down by 10%. Table B.6 displays the change in total benefits when different discount rates are applied.

Table B.3 – Benefits per year, by measure

Beneficiary	Nominal	Deflated to 2025	Discounted to 2025
Providers	$91 million	$56 million	$36 million
Worker	$88 million	$55 million	$34 million
Total	**$180 million**	**$111 million**	**$70 million**

Figures are rounded and totals may not sum exactly.

Table B.4 – Breakdown of benefits

Measure	Hours saved	Equivalent wages	Fees saved	Total benefit per year	Equivalent care hours
Providers	182,000 hours	$23 million	$68 million	$91 million	1.1 million hours
Workers	419,000 hours	$28 million	$60 million	$88 million	1.1 million hours
Total per year	601,000 hours	$52 million	$128 million	$180 million	2.2 million hours
Total, 10 years	**6 million hours**	**$517 million**	**$1,279 million**	**$1,796 million**	**21.9 million hours**

Provider equivalent wages include overhead costs. Numbers are rounded and may not sum.

Table B.5 – Sensitivity testing on nominal results, varying key variables +/-10%

Variable	Minus 10%	Plus 10%
Inflation	-4.7%	4.9%
Average wage, provider cost	-1.3%	1.3%
Average wage, sector average	-1.6%	1.6%
Provider growth	-6.5%	7.0%
Hours per audit	-1.3%	1.3%
Fees per audit	-3.8%	3.8%

Variable	Minus 10%	Plus 10%
NDIS workers	-4.9%	4.9%
% of NDIS clients under 18	-4.9%	4.9%
Years between screenings	5.5%	-4.5%
Worker screening fee	-3.3%	3.3%
Worker time per screening	-1.6%	1.6%

Table B.6 – Sensitivity testing on nominal 10-year benefits, varying discount rates

Discount rate	Total benefits	Per year benefits
0% (nominal)	$1,796 million	$180 million
3%	$1,186 million	$119 million
7% (rate used for final results)	$701 million	$70 million
10%	$483 million	$48 million

Note: Discount rates are used to adjust future benefits so they can be compared to present-day values. The higher the discount rate, the less future benefits are worth in today's terms.

Embed collaborative commissioning to increase the integration of care services

Our approach

Chapter 2 of this report proposes a series of reforms to embed collaboration between Primary Health Networks (PHNs), Local Hospital Networks (LHNs) and other organisations. The reforms are focused on governance settings, funding arrangements and other changes required to support effective collaborative commissioning that tailors services to local needs.

The benefits of this reform will ultimately depend on the programs undertaken by individual organisations and how they are delivered. However, there are several existing case studies of collaborative commissioning that can provide guidance of the types and magnitudes of benefits we can expect.

Our approach to quantifying the benefits of collaborative commissioning is to estimate how collaborative commissioning could reduce potentially preventable hospitalisations (PPHs) and emergency department (ED) presentations. Underpinning this is the assumption that each PHN will undertake one or more collaborative commissioning programs that combined have a similar sized effect on the relevant populations as existing cases.

In the interim report, we said that a 10% fall in PPHs would lead to $600 million in annual savings. This was presented to illustrate the potential scale of the benefits if a 10% reduction could be achieved, rather than an empirical estimate of what we believe the benefits will be. Indeed, The George Institute for Global Health (sub. 154, p. 6) submitted that a 10% reduction from this reform alone is too ambitious in the short term.

Methodology and data sources

In the final report, we calculated the number of reductions in ED presentations and PPHs from the published results of existing case studies and divided this by the population in the PHN catchment. Where the program did not apply across the entire PHN, we used the relevant sub-population. In some cases, we used the published savings to estimate the reductions in ED presentations and PPHs. To avoid double counting, the estimated fall in ED presentations excludes ED presentations that would have resulted in a PPH.

We found that PPHs fell between 4.1% and 5.7% and ED presentations fell between 0.1% and 8.3%. Calculating a mean of these estimates, we conclude that our reform can reduce PPHs by 5% and ED presentations by 4% based on existing case studies of collaborative commissioning (table B.7), though these gains will not necessarily be realised in the short term.

Table B.7 – Collaborative commissioning reduces PPHs and ED presentations

Program	Published results
Collaborative Commissioning (Northern Sydney LHD and Sydney North Health Network)	51% fall in ED presentations and unplanned hospital admissions, saving $10.9 million in 2023.
Aged Care Emergency service (Hunter New England LHD, Hunter New England Central Coast PHN and Hunter Primary Care)	20% fall in ED presentations and a 21% fall in the rate of hospital admission.
Care Collective (Brisbane North PHN and Metro North Health)	Saving of $429,000 per month based on avoided ED presentations and the resulting avoided admissions.
Working Together to Connect Care (Brisbane North PHN and Metro North Health)	438 fewer hospital admissions in six months and an 11% fall in avoidable ED presentations.
Western Sydney Integrated Care Program (Western Sydney LHD and Western Sydney PHN)	37% fall in PPHs and a 32% fall in ED presentations.

Source: AHHA (2024); Brisbane North PHN (2025); Cheung et al. (2019, p. 569); Hullick et al. (2021, p. 206); The Health Alliance (sub. 84, p. 9).

There are limitations with this approach.

- Existing collaborative commissioning evidence could be more readily available for examples of successful programs due to publication bias, meaning that we do not observe a representative sample of all programs. Moreover, only a small number of cases were analysed.
- There is variation in underlying health needs as well as workforce capabilities across Australia.

We then quantified the estimated reduction in PPHs and ED presentations as dollar savings. This estimate does not consider the cost to the health care system of the programs required to avoid PPHs and ED presentations.

We drew on the number of PPHs that occur annually in public hospitals and the average length of stay associated with PPHs to find the total number of bed days used to treat all PPHs in public hospitals. This was multiplied by the average cost of a bed day to find the cost of PPHs on public hospitals. From this, a 5% reduction in PPHs leads to an annual saving of about $312 million. Figures have been converted to 2025 dollars using the CPI health deflator where necessary.

We also drew on the number of ED presentations in public hospitals and the cost of a non-admitted ED presentation to find the cost of ED presentations on public hospitals. A 4% reduction in ED presentations gives a saving of about $284 million.

Combined, the reductions in PPHs and ED presentations are equivalent to about $600 million annually (table B.8).

Table B.8 – Data used to calculate savings from our reform

	Estimate	Source
Number of PPHs in public hospitals (2023-24)	599,060	PC estimates based on AIHW (2025c)
Average length of stay associated with a PPH	4.05 days	PC estimates based on AIHW (2025d)
Number of bed days in public hospitals used to treat PPHs	2,426,400	PC estimates based on AIHW (2025d, 2025c)
Average cost of a bed day	$2,574	PC calculation from the cost of a separation ($5,315) divided by average length of stay for admitted acute care (2.34 days) converted to 2025 dollars (IHACPA 2023, p. 4)
Saving from a 5% reduction in PPHs	$312 million	PC calculation
Number of ED presentations in public hospitals (2023-24)	9,018,401	AIHW (2025a)
Cost of a non-admitted ED presentation	$787	PC conversion to 2025 dollars from the Report on Government Services (2025c, p. 128)
Saving from a 4% reduction in ED presentations	$284 million	PC calculation
Combined saving from reductions in PPHs and ED presentations	$596 million	PC calculation

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

Chapter 3 of this report recommends that the Australian Government establish a National Prevention and Early Intervention Framework to support government investment and includes some indicative estimates of the potential benefits of increased investment in this area. Investment in prevention and early intervention can produce significant benefits to individuals, government and the community compared to costs. The approach taken to produce indicative estimates is outlined here.

Our approach

Estimating benefits of the proposed framework requires assumptions about the types of interventions, the amount and timing of investment, the expected benefits and the timeframe over which those benefits are realised.

Washington State Institute for Public Policy

To produce illustrative estimates of the potential benefits of a framework to support government investment in prevention and early intervention, we drew upon program evaluation data from the Washington State Institute for Public Policy (WSIPP) (WSIPP 2024a). The WSIPP cost–benefit model provides estimates of the value of implementing programs across a range of areas including health, education and justice, and allows comparison of the monetised benefits of improved outcomes with the associated program costs (WSIPP 2024b).

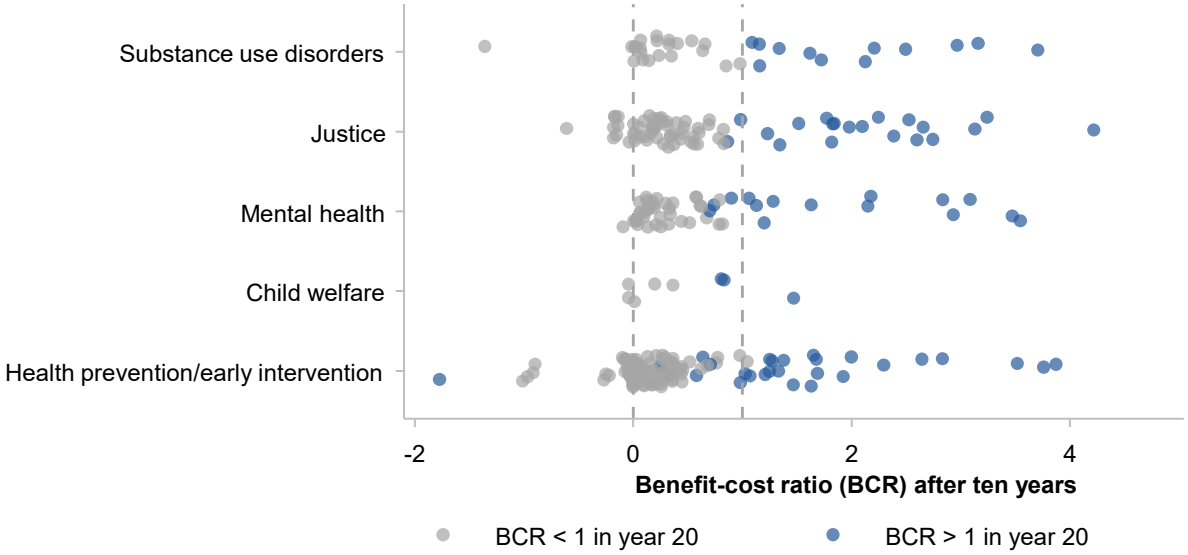
Monetised 'flow-on' benefits include increased labour market earnings, lower costs (in areas such as healthcare, justice, social assistance and education), reduced mortality risk, and smaller deadweight losses from market inefficiencies. The WSIPP provides estimates of these costs and benefits over time and across different stakeholders, including individuals, taxpayers, and the broader community.

The analysis in this appendix uses a narrow definition of benefits, focusing on potential returns to the taxpayer. Given that the programs in the WSIPP data are from the United States, results are only illustrative of possible returns in the Australian context.

The WSIPP dataset includes cost–benefit results from a range of portfolio areas and with differing levels of success. To develop a representative bundle of potential investments, a subsample of health, justice, child welfare, substance abuse, and mental health programs were used. After removing extreme outliers, cost–benefit data remained for 301 programs. Of these, around 30% are expected to result in taxpayer benefits that are greater than the initial expenditure over the long-term (they have a benefit–cost ratio greater than one) (figure B.1).

Figure B.1 – Benefits to taxpayer from prevention and early intervention vary by policy area

Benefit–cost ratio after ten years



Source: PC estimates using Washington State Institute for Public Policy cost–benefit data (WSIPP 2024a).

Potential benefits to the taxpayer from implementation of a National Prevention and Early Intervention Framework were estimated using WSIPP program data, on the assumption that funding would be invested in programs that deliver returns to government greater than their initial cost after 20 years. This would represent a portfolio of investments, that would likely have a range of returns. Overall, the portfolio would likely have a positive return to the taxpayer over the long term. The assumed return used in estimating possible benefits for the framework is the unweighted mean benefit–cost ratio of these programs in each year after implementation. The mean benefit–cost ratio is shown with different discount rates applied to future benefits in figure B.2.

Indicative benefits

Returns to government gradually increase over time following the initial investment. Avoided costs to government would be expected to surpass initial investment after five years, and after ten years the expected fiscal benefits could be around 2.09 times the initial investment.

An investment of $1.5 billion over five years could save governments around $2.7 billion over the ten years after the initial investment. The net present value of the potential savings would be about $1.9 billion in current dollars. This is calculated on the assumption that $300 million would be spent in each of those five years. Estimated savings would be to the taxpayer only and do not include private benefits.

Private and community benefits that result from included programs were also estimated but are not the focus of this analysis. These additional benefits include expected increases in earnings, changes in physical and mental health and other improvements in wellbeing. Including broader benefits as well as those to the taxpayer suggests the total value of benefits expected over ten years to be $7.7 billion, with a net present value of $5.4 billion. These benefits will continue to accrue over time.

Discount rates

The rate at which any future savings are discounted will affect the present value of those expected savings. While the WSIPP applies a discount rate of 3.5% to future benefits, this discount was removed and a 7% discount rate on future benefits was applied, as advised by the Office of Impact Analysis (2023).

A number of submissions recognised that the choice of discount rates used in cost–benefit analysis has the potential to limit government investment in prevention.[40] For example:

> [discounting] can be problematic in health economic models evaluating the long-term outcomes of prevention where costs are predominantly upfront and benefits take long periods to eventuate. In these models … discounting can have a significant impact, generating uncertainty, and potentially making prevention appear less cost-effective compared to interventions with short-term effects. (HEPER Group, Faculty of Pharmacy and Pharmaceutical Sciences, Monash University, sub. 174, p. 3)

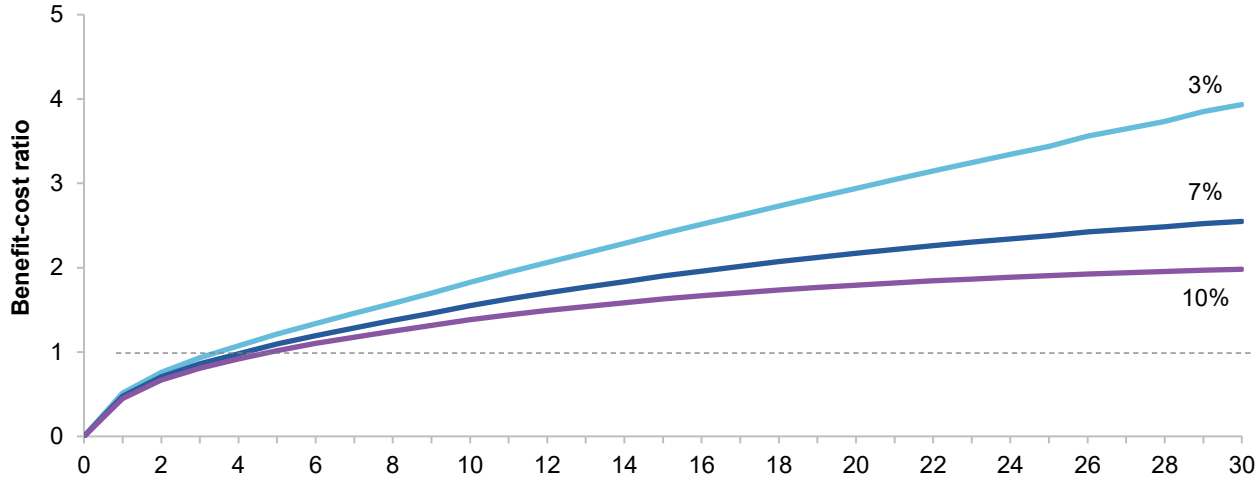
> We encourage any future framework that is developed to assess the economic credentials of preventive interventions by carefully considering which discount rates should be adopted in the base case and sensitivity analyses used to assess the impact of varying these. PBAC and MSAC currently use 5%, however other jurisdictions internationally use lower rates. (HEG, sub. 243, p. 5)

The choice of discount rate has a substantial impact on estimates of potential benefits of all government programs (figure B.2). Higher discount rates make investments delivering benefits in shorter amounts of time more attractive, and those that result in benefits further in the future are accorded less value. When using the 7% discount rate advised by the Office of Impact Analysis rather than the lower 3% rate it suggests for sensitivity analyses, the potential benefits of a preventive framework are estimated as being 25% less after 20 years, and 33% less after 30 years.

[40] AMA (sub. 94, p. 5), CHA (sub. 165, p. 46), GSK (sub. 139, pp. 7–9), Jaithri Ananthapavan (qr. 33, p. 2), Medicines Australia (qr. 81, pp. 2–3), PHAA (sub. 16, p. 6), SVA (sub. 163, p. 11), Prevention Centre (qr. 86, p. 3).

Figure B.2 – Discount rates have a substantial impact on estimates of taxpayer benefits

Average benefit–cost ratio by discount rate over time



Source: PC estimates using Washington State Institute for Public Policy cost–benefit data (WSIPP 2024a).

Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
ACCO	Aboriginal Community Controlled Organisation
ACDC	Australian Centre for Disease Control
ACQSC	Aged Care Quality and Safety Commission
AI	Artificial intelligence
AIHW	Australian Institute of Health and Welfare
BCR	Benefit–cost ratio
BiOC	Birthing in Our Communities
COVID-19	Coronavirus disease of 2019
DTF	The Victorian Department of Treasury and Finance
DSS	Department of Social Services
ECEC	Early childhood education and care
ED	Emergency department
EIIF	Early Intervention Investment Framework
ERC	Expenditure Review Committee (of Cabinet)
FFA	Federation Funding Agreement
GDP	Gross Domestic Product
GP	General practitioner
HHS	Hospital and Health Service
IHACPA	Independent Health and Aged Care Pricing Authority
IQ	Intelligence quotient
IT	Information technology
IUIH	Institute for Urban Indigenous Health
LHN	Local Hospital Network
MSAC	Medical Services Advisory Committee
NDIS	National Disability Insurance Scheme
NDIS Commission	National Disability Insurance Scheme Quality and Safeguards Commission
NHRA	National Health Reform Agreement
OECD	Organisation for Economic Co-operation and Development
OIA	Office of Impact Analysis
OOHC	Out-of-home care

PBS	Pharmaceutical Benefits Scheme
PC	Productivity Commission
PEIFAB	Prevention and Early Intervention Framework Advisory Board
PHN	Primary Health Network
PLIDA	Person-Level Integrated Data Asset
PPH	Potentially preventable hospitalisation
QCP	Queensland-Commonwealth Partnership
qr	Questionnaire response
UK	United Kingdom
SoE	Statement of expectations
US	The United States of America
WSIPP	Washington State Institute for Public Policy
WWCC	Working with children check

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