AHHA Submission to the Delivering quality care more efficiently consultation

Submission

16 June 2025

OUR VISION

The best possible healthcare system that supports a healthy Australia.

OUR PURPOSE

To drive collective action across the healthcare system for reform that improves the health and wellbeing of Australians.

OUR GUIDING PRINCIPLES

Healthcare in Australia should be:

Outcomes-focused
Evidence-based
Accessible
Equitable
Sustainable

OUR CONTACT DETAILS

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INTRODUCTION

The Australian Healthcare and Hospitals Association (AHHA) welcomes the opportunity to contribute to the Productivity Commission's consultation on Delivering quality care, more efficiently.

This submission builds on consultation undertaken with health system leaders in developing a blueprint for health reform towards outcomes-focused, value-based health care, and AHHA's operating model of continuously listening to and engaging with the experiences and evidence from our members and stakeholders, as we contribute to the evolution of our health system.

ABOUT THE AHHA

For more than 70 years, AHHA has been the national voice for public health care, maintaining its vision for an effective, innovative, and sustainable health system where all Australians have equitable access to health care of the highest standard when and where they need it.

As a national peak body, we are uniquely placed, in that we do not represent any one part of the health system. Rather, our membership spans the system in its entirety, including – public and not-for-profit hospitals, PHNs, community, and primary healthcare services.

Our research arm, the Deeble Institute for Health Policy Research connects universities with a strength in health systems and services research, ensuring our work is underpinned by evidence.

In 2019, AHHA established the Australian Centre for Value-Based Health Care, recognising that a person's experience of health and health care is supported and enabled by a diverse range of entities, public and private, government and non-government. The Centre brings these stakeholders together around a common goal of improving the health outcomes that matter to people and communities for the resources to achieve those outcomes, with consideration of their full care pathway.

Through these connections, we provide a national voice for universal high-quality health care. It is a voice that respects the evidence, expertise, and views of each component of the system while recognising that siloed views will not achieve the system Australians deserve.

OUR RESPONSE

SECTION 1. ABOUT YOU AND/OR YOUR ORGANISATION

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Q. May we contact you about your response?
Yes.

Q. How would you prefer we contact you?
Email.

Q. Whose views does your organisation represent?
The Australian Healthcare and Hospitals Association Limited (AHHA Ltd) is Australia's national peak body for public and not-for-profit hospitals and healthcare providers.

Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Primary Health Networks and primary care providers, aged care providers, universities, individual health professionals and academics.

As such, we are uniquely placed to be an independent, national voice for universal high-quality healthcare to benefit the whole community.

Q. Do any of the attributed parties identify as Aboriginal or Torres Strait Islander/are any identified organisations an Aboriginal or Torres Strait Islander organisation?
N/A

Q. Do the attributed parties consent to the PC publishing your response on our website and referring to it in our reports?
Yes

Q. Guidelines and policies agreement:
I have read and agree to the above guidelines and policies.

Q. Will you be providing any documents to support your response?
No.

Q. For the purposes of this consultation, which of the following best describes you:

- I am a consumer or user of care services
- I am a carer of someone who uses care services
- I am a care worker
- I am an organisation that provides or coordinates care services
- **I am an industry or advocacy organisation, professional association or peak body**
- I am a government department/agency
- I am an interested community member

Q. Which of the following care sectors will your feedback relate to?

- Aged care
- Disability
- Early childhood education and care
- **Health**
- Veterans
- Aboriginal Community Controlled
- Other

Q. What kind of care supports, services and programs do you have experience with, and in what jurisdictions?

As a national peak body for public and not-for-profit healthcare, we are uniquely placed, in that we do not represent any one part of the health system. Rather, our membership spans the system in its entirety, including – public and not-for-profit hospitals, PHNs, community, and primary healthcare services.

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In 2019, AHHA established the Australian Centre for Value-Based Health Care, recognising that a person's experience of health and health care is supported and enabled by a diverse range of entities, public and private, government and non-government. The Centre brings these stakeholders together around a common goal of improving the health outcomes that matter to people and communities for the resources to achieve those outcomes, with consideration of their full care pathway.

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Evidence of our consulting work across Australia's healthcare system is available on our website.

Q. We are seeking responses to questions on three policy reform areas. Which policy reform areas would you like to respond to?

All of the reform areas.

SECTION 2. REFORM OF QUALITY AND SAFETY REGULATION TO SUPPORT A MORE COHESIVE CARE ECONOMY

Q. To what extent do differences in quality and safety regulation make it costly or complex to provide or access care services?

- ☐ Not at all
- ☐ Very little
- ☒ **Somewhat**
- ☐ To a great extent

Q. What are the reasons for your answer?

Safety and quality regulation plays a pivotal role in enabling our healthcare system to consistently deliver quality care that improves the wellbeing of Australia's population. With the volume of activity that occurs across the system, regulations to ensure a high standard of care are extensive, comprising the registration and accreditation of the health workforce (AHPRA), setting of clinical care standards (ACSQHC), and health technology assessments for the distribution and use of medical devices and pharmaceuticals (TGA)[1].

Despite their role in maintaining a high standard of care across the system, a lack of harmony across regulatory frameworks has inadvertently contributed to inconsistency, duplication, and fragmentation in care delivery, creating unnecessary complexities and undermining the safe and quality health system Australians expect and deserve.

We identify three key consequences of regulatory disharmony:

1. Inflexibility in adapting to contemporary models of care

Safety and quality regulation has not kept pace with shifts towards integrated, team-based care, instead having created a highly rigid authorising environment that reinforces a fragmented, profession-centric approach to care delivery. This is despite the fact that team-based care is recognised as important to the quality and safety of care delivery, and as demand for flexible models of care continues to grow with ageing populations and an increasing prevalence of multimorbidity[2].

Modelling of Australia's future health workforce needs project significant unmet supply. For General Practitioners alone, estimates show a shortfall of 3,900 FTE in 2028, doubling to 8,900 FTE by 2048[3]. As the gatekeepers to Australia's public healthcare system, GP shortages reflect critical accessibility issues to necessary care, an issue already greatly felt in rural and remote areas. In these thin - if non-existent - markets, the rigidity in contractual obligations to which health professionals are regulated to deliver specific services means that already scarce services are often unsupported to flexibly provide care that meets local community needs and that professionals want to deliver[4].

Team-based models of care can, in part, help to address these workforce supply issues by enabling care to be delivered by an available, appropriately trained and skilled health professional who can carry out the relevant activity, as it falls within their full scope of practice. This however is dependent upon a regulatory environment that moves beyond its historical, prescriptive approach that is protective of title and enables continuing system fragmentation, to one that is reflective of the current operating environment and growing movement towards a person-centred, outcome-focused, and value-based health care system.

The challenges to flexible care delivery and establishment of multidisciplinary care teams stemming from existing regulations is well documented within the 2024 *Unleashing the Potential of Our Health Workforce – Scope of Practice Review*[5], which in its summary of recommendations to regulation notes,

'*The proposed reform and harmonisation of legislation and regulation will create a system that is more consistent, balanced, adaptive and responsive*.' (p.16)

Explicit solutions to reforming and harmonising legislation and regulation are described in detail within the report.

2. Increased administrative burden and impact on workforce wellbeing

Duplication and misalignment between regulatory bodies, particularly in reporting requirements, is contributing to a growing administrative burden on an already resource-poor workforce.

For example, accreditation standards are an important part of assuring quality and safety. However, in rural and remote areas, services are often providing services across health, mental health, aged, and disability sectors, due to thin or no markets. The administrative burden associated with demonstrating compliance across multiple, often duplicative and at times conflicting or inconsistent, standards, can be prohibitive to accessible, timely, effective and efficient service provision.

This not only diverts time from direct care but can foster cynicism about the value of regulation itself, ultimately undermining both staff morale and consumer and community trust. Evidence demonstrates that if the benefits of accreditation beyond compliance are not made clear, the immediacy of intangible costs, such as the administrative burden and the diversion of efforts and resources and frontline care, can risk clouding the perceived value of accreditation and thereby compliance[6].

Misalignment between the value of regulation reporting requirements, where treated as compliance rather than ongoing quality improvement, and care delivered can erode at the wellbeing of the health workforce, disconnecting clinicians from their purpose and intrinsic motivation as healers[7]. Protecting healthcare worker wellbeing is a priority for attracting and retaining the healthcare workforce[8]. Opportunities to harmonise regulation to reduce unnecessary administrative burden can therefore enable clinicians to reconnect to their work, with time spent providing care as opposed to meeting administrative demands, supporting the objective of the regulations without the administrative burnout. That is, the delivery of safe and quality care.

3. A compliance-first culture that deprioritises outcomes

The volume of safety and quality regulations, while important to ensuring the breadth of activity across the health system is appropriately managed and supported, is so great that balancing the demands for service delivery against the significant reporting requirements has fostered a 'tick-in-the-box' culture. This is a separate, but aligned, challenge to the administrative burden effects on workforce wellbeing, evidenced in the inconsistencies in orientation of regulation (e.g., some focused on compliance, while others to learning cultures and continuous improvement).

Regulatory frameworks too often reinforce a focus on inputs and outputs, rather than on their purpose to drive improvements in outcomes and generate value across the system. That is, where the

goal of service delivery becomes compliance rather than meeting patient needs and delivering the outcomes that matter.

Accreditation, in particular, has received commentary suggesting that it's purpose to maintain high quality and ensure patient safety in care delivery has 'failed', evidenced in the variation of hospital complication rates, and high-profile examples of safety failures in healthcare resulting in poor experiences, or in serious cases, patient deaths[9]. This is despite the volume of regulatory frameworks to prevent this from occurring.

The need to reorient towards a person-centred, outcomes-focused approach to the harmonisation of safety and quality regulation is paramount in addressing what are real-world consequences for patient outcomes, system efficiency, and workforce sustainability. While AHHA cannot speak directly to the specifics of what safety and quality regulation deserves consideration for reform opportunities, we recognise that better alignment in safety and quality regulation is timely and essential. We support the Commission's inquiry into this space and welcome further opportunities to contribute to the design of a more cohesive and adaptive regulatory environment.

Q. To what extent should safety and quality regulations be more aligned across the different care service sectors and jurisdictions?

- ☐ Not at all
- ☐ Very little
- ☐ Somewhat
- ☒ **To a great extent**

Q. What are the reasons for your answer?

Delivering the healthcare system that Australians expect and deserve requires moving away from siloed responses and fragmented regulatory frameworks. Aligning safety and quality regulations to support the health workforce to meet the changing care needs of Australians demands a collaborative, cross-sector and cross-jurisdiction approach.

Central to this approach must be people and communities. While the principle of person-centred care is widely endorsed, vested interests, within and between professions, sectors and jurisdictions, continue to undermine opportunities to enact sustainable system-wide reform.

Harmonisation of safety and quality regulation provides an opportunity to realise an integrated healthcare system, where people and communities are placed at the centre of decision-making between parties across sectors, professions, and jurisdictions. Leadership will be critical to championing this reform, not only in enabling innovative models of care that reflect the consumer journey across a full pathway of care, but in transitioning the understanding of safety and quality regulation as a 'point in time' exercise in compliance, to one of system-wide continuous improvement. This cultural shift, from regulation as oversight to regulation as a core component to a learning health system, requires strategic commitment and practical action at all levels of the system.

Consumers, communities, healthcare professionals and providers can all benefit from health professionals working within a harmonised regulatory system – but only if reform is pursued for the purpose of enabling person-centred healthcare system, where all parties come together to address the shared needs of Australians.

SECTION 3. EMBED COLLABORATIVE COMISSIONING TO INCREASE THE INTEGRATION OF CARE SERVICES

Q. What is your experience with collaborative commissioning?

AHHA has supported Western Queensland Primary Health Network (WQPHN) to embed collaborative commissioning at the core of its model for commissioning – the *Outcomes for the Outback* framework. This approach responds to the unique environmental and geographic challenges of rural and remote Queensland — particularly in areas characterised by thin or non-existent service markets, cross-sector fragmentation, and high health inequity.

The WQPHN approach reflects the principles of relational commissioning, as outlined in The King's Fund's *Thinking differently about commissioning* report[10]. It sets the expectation and operationalisation of shared decision-making, co-design, and joint planning in place, with local Hospitals and Health Services, Primary Care Providers, Aboriginal and Torres Strait Islander Community Controlled Health Organisations (AICCHOs), local government, and NGOs. The seven Commissioning Localities (CLs) established across Western Queensland provide a current example of this in practice (see **Box 1**).

Box 1 Commissioning Localities

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

Although still in rollout, early observations suggest that collaboration through place-based commissioning localities will lead to stronger alignment of services, better use of local insights, and more flexible and responsive investment in care. Key success factors identified include:

- **A nationally unified, regionally responsive structure:** Strategic alignment in priorities across and between federal, state, and local communities via use of a Joint Regional Health Needs Assessment.
- **Relational governance agreements:** For example, the Maranoa Accord and the Nukal Murra Health Alliance[11], which formalise relationships with AICCHOs and HHSs, and alliances with community and service providers in localities.
- **Shared planning and investments:** Supported by an Outcomes Framework that enables collective accountability and system-wide monitoring.

While long-term outcome data are still emerging, the approach is designed for achieving health outcomes that matter to people and communities, sustainably and equitably, through continuous adaptation with evaluation embedded throughout the commissioning cycle.

Source: Western Queensland PHN[12]

Regarding funding, it is important to distinguish that collaborative commissioning is the foundational model and approach WQPHN uses to deliver its core commissioning responsibilities. As such, WQPHN's commissioning approach is currently focused on strengthening relationships, embedding joint planning, and building place-based governance structures that bring together all parts of the service system.

Already underway, the next stage in the commissioning evolution involves adjusting procurement and funding mechanisms to reflect and support this collaborative foundation. This includes exploring alliance contracting, pooled funding, and co-commissioning models that move beyond siloed, output-based arrangements toward shared investment in outcomes.

Importantly, this approach to commissioning enables local planning that identifies what services are already in place, how care is being delivered, and how existing capacity can be better coordinated to meet population needs. It supports reducing duplication, aligning service design across sectors, and improving delivery regardless of who provides the service or how it is funded. This is especially critical in rural and remote contexts where markets are thin or non-existent and where fragmented funding and governance arrangements can otherwise create barriers to care.

Under a collaborative commissioning model, the consequences of a fragmented health system on consumers are mitigated, with a focus on designing care around the outcomes that matter to people and communities - not programs or funding silos.

While initiatives such as Healthy Outback Communities (see **Box 2**) exemplify the commissioning-for-outcomes shift, future iterations will increasingly reflect these collaborative funding and governance models in practice, aiming to deliver better value, equity, and continuity of care in even the most resource-constrained settings.

AHHA would welcome the opportunity to discuss any aspect of this work with WQPHN further, as it is ongoing.

Box 2 Healthy Outback Communities (HOC)

Healthy Outback Communities is a collaborative model of health and social care that aims to improve health access, equity, and outcomes in the very remote Western Queensland shires of Boulia, Diamantia and Barcoo. The isolated region spans almost 220,000 sq km, equivalent to the size of Victoria. Current service delivery does not adequately meet the essential needs of the 1,100 residents of these communities due to the absence of resident GPs, pharmacists and dedicated healthcare professionals.

Aim: Cross-sector engagement for transformative, sustainable change.

Objectives:

- Person-centred: Co-designing Individual and Community Wellbeing Plans across life-stages
- Collaborating with the HOC Alliance for accessible, responsive and flexible deployment
- Integrating Universal Wellbeing to complement VBHC for improved outcomes
- Applying technology for continuity of wellbeing with clinical support

Outcomes:

- Comprehensive, multi-level program of engagement
- Dedicated HOC Alliance for overarching governance
- Collaborative community and primary care partnerships secured for co-design, co-investment and flexibility in allocating resources for service delivery and follow-up
- Local community engagement
- Key issues defined by local communities

Source: (AHHA[13])

Q. What are the benefits of pursuing greater collaborative commissioning?

Greater collaborative commissioning can significantly reduce duplication, close service gaps, and improve health outcomes[14], particularly in rural and remote areas where challenges to addressing complex needs in isolation are compounded by systemic issues in workforce, data, funding, and governance.

Some key benefits identified in our experiences with collaborative commissioning include:

- **Integrated care for individuals and communities:** Collaborative commissioning fosters person-centred models that bridge siloed systems (e.g. health, disability, aged care), making care more seamless and culturally responsive.
- **Improved efficiency and value for money:** Joint planning, shared knowledge and pooled resources reduce duplication, streamline delivery, and target investment toward interventions that achieve shared outcomes across services and areas.
- **Increased equity and system responsiveness:** Commissioning that is locally informed and collectively governed allows communities to shape solutions that reflect their unique needs and values, improving access to and trust in care.

- **Innovation and shared accountability:** Partnerships promote innovation through shared data and data transparency, co-design processes, and mutual learning. When backed by funding models that incentivise outcomes, they also create a culture of joint accountability across the system.

Understanding what matters to people, and how the healthcare system can innovatively and sustainably respond, are essential for system reform. By shifting from transactional contracting (otherwise known as procurement) to strategic, outcomes-based investment, collaborative commissioning transforms the role of funders and providers from service deliverers to partners in system reform working together to deliver sustainable impact.

Q. What are the barriers to collaborative commissioning, and do you have any suggestions for solutions that would lead to better collaboration in the commissioning of care?
There are several barriers to collaborative commissioning, especially in rural contexts:

Barrier	Proposed solution
Fragmented funding and governance Different funding streams (federal/state), inconsistent reporting requirements, and sectoral mandates (eg: health, aged care, disability) creates complexity and increases administrative burden.	**Flexible, long-term funding models** Introduce shared planning frameworks, joint governance agreements, and enable pooled or flexible funding models that align service delivery with community needs—regardless of funding source.
Lack of shared data systems Siloed and inaccessible, or non-transparency of data makes it difficult for commissioners and providers to identify allocation and availability of funding, shared priorities, monitor population outcomes, or track the impact of investment across care pathways.	**Fit-for-purpose performance reporting** Invest in interoperable data infrastructure and cross-sector data sharing agreements, supported by joint outcome frameworks and local health intelligence capacity.
Workforce and capacity constraints In thin markets, limited provider capacity can make joint commissioning risky or unviable without targeted support…	**Integrated, resilient workforce investments** …if supported well, it could address these constraints in the medium to long term.
Misaligned incentives and short-term funding Traditional procurement and performance frameworks often prioritise activity and compliance over collaboration and outcomes, and they pose barriers to joint ownership or long-term reform.	**Scalable, value-based payment models** Transition to outcomes-based funding models that reward shared results and allow flexible use of resources over time. Embedding collaborative commissioning principles into funding guidelines and contracts would also support cultural and behavioural change.

Overarching solutions to address the previously described systemic barriers to effective, quality care delivery include:

- **Establish joint governance mechanisms** (e.g., alliances, regional partnerships) with clear terms of reference, co-accountability for outcomes, and aligned investment priorities.
- **Enable pooled or blended funding models** that are flexible across sectors and responsive to local context—particularly for cross-cutting needs such as chronic disease or elder care.
- **Invest in enabling infrastructure**, such as shared data systems, relational commissioning capability, and regional workforce planning.
- **Create incentives for collaboration**, including commissioning approaches that prioritise alliances, consortia, or co-design over competitive procurement.
- **Support / utilise Aboriginal-led governance and service models** by recognising the cultural, social, and clinical strengths of AICCHOs and embedding their leadership in collaborative structures.

Policy reforms that support these enablers, notably the recommendation for flexible funding under the National Health Reform Agreement Mid-Term Review and a review and reform of current commissioning guidelines, would help scale and spread collaborative commissioning models and improve the sustainability and equity particularly of rural health systems.

SECTION 4. A NATIONAL FRAMEWORK TO SUPPORT GOVERNMENT INVESTMENT IN PREVENTION

Q. What are the main barriers to governments investing in evidence-based prevention programs across the care economy?

Economic pressures on government expenditure and budgets are at historical highs, across both state and federal levels[15]. Despite increasing demands for prevention based programs and services, these financial constraints are creating complex decision-making environments in health care, where providers are being asked to deliver more with less (in funding, workforce, and time) while still being required to deliver high quality care. Although this has been an ongoing challenge for some time, the epidemiological transition in healthcare needs has accelerated the instability of our current approach to health system expenditure, if not more broadly to the structure of the health system itself.

A preventive approach to healthcare planning underscores the importance of how health should be seen as an investment, not just a cost, and provides an opportunity to reorient the health system to embed resilience and build the future-proofed health system Australians expect and deserve. Expenditure on prevention can contribute to budget repair by reducing future demand on the health system while simultaneously improving health outcomes and quality of life, lessening the individual, intergenerational and health system burden which will otherwise continue to compound into the future[16].

Yet, in our experience, we identify there are multiple structural systemic challenges undermining opportunity to sustainably invest in preventive care.

1. Misaligned, fragmented and short-termed funding

The Australian healthcare system is characterised by antiquated, short-term funding models that limit innovation and integration – both central to enabling long-term investment in preventive care across the system.

Funding responsibilities are siloed across federal and state governments for some programs and services, while responsibilities are shared for others, such as public hospitals. Different funding models are used to fund similar types of care, depending on where care is delivered and by what type of organisation. This increases funding complexity, encourages cost shifting between sectors, and limits opportunities for coordination between services across a full pathway of care[17].

Additionally, the dominant funding models used, such as fee-for-service or activity-based funding, are primarily designed to support acute, episodic care by reimbursing providers based on the volume of services delivered. These models inherently disincentivise preventive activities, which often do not generate immediate, billable services (requiring extended periods of time between services to see effects realised) impeding provider revenue and long-term business viability[18].

Capturing the value of preventive activity is also undermined by traditional measures used by current funding models, where outputs (such as duration, complexity of service, or volume) are collected, as opposed to the outcomes achieved. The effect of this on timely, proactive investment by government and providers is more pronounced when considering the time-lag between preventive initiatives and the outcomes delivered, of which is often times many years longer than current funding cycles.

2. A focus on outputs rather than outcomes in care

Data is a key component of achieving high-quality, high-value, safe and equitable care. Enabling this requires health data to be accurate, in the right format, timely, and of sufficient quality to discern critical relationships between investments and results, as appropriate, for different purposes.

Despite the substantial volume of data collected to inform decision-making across all levels of the system, traditional measures often fail to capture the true value of care, particularly for preventive care. In the National Health Reform Agreement, for example, 'potentially preventable hospitalisations' are a health system performance indicator of accessibility and effectiveness, as well as a key indicator for Primary Health Networks (PHNs) in assessing their objective of improving coordination of care to reduce hospitalisations[19]. Such a measure has significant limitations as an indicator of variation in the provision or quality of care, in that:

- Not all hospitalisations captured could have been prevented, at least in the short term, due to the time-lag between prevention interventions and disease onset or complications, and
- Not all hospitalisations captured could have been addressed solely by the health system, in that most chronic conditions require a multidisciplinary, cross-sector approach to address the social determinants of health (e.g., socioeconomic status).

Without a focus on consumer outcomes and experiences, it will remain a challenge to fully capture the impact of preventive care interventions and inform evidence-based decision-making in healthcare. Yet even where outcomes data is collected, bringing together this information from different sources in a way that is easy to understand and act on is undermined by challenges in standardisation, digital interoperability, and administrative burden.

While Australia's data linkage capability has grown substantially over the past decades, collected healthcare data continues to remain steadfastly siloed. The lack of standards and regulation of health data has led to inconsistent structures, data elements and use of clinical terminologies and classifications[20]. It also contributes to significant re-divestment of service resources into measuring and reporting of data by the health workforce, reducing clinician capacity for time spent with consumers in delivering care that matters.

3. Structural workforce challenges undermining flexible, responsive care

Effective preventive interventions require ongoing, coordinated continuity of care. Principle to this is a health workforce that is available, affordable, adaptive, and accessible, able to proactively meet the changing needs of the person at the centre of care through multidisciplinary team-based models of care.

Yet continuing, systemic challenges are facing Australia's health workforce and undermining the ability to provide care as it is, let alone in a way that best enables effective preventive care. These challenges are diverse, and not unique to Australia: workforce shortages, skill-mix imbalances, maldistribution, vested interests, hierarchical professional structures, misaligned funding incentives, regulatory requirements (e.g., scope of practice, administrative burden), a limited availability of health workforce data[21].

4. Siloed systems and disconnected governance

Preventive care requires coordinated and sustained action not just within care teams, but across sectors, including health, housing, education, employment, social services, justice, and other sectors, recognising that the most significant drivers of health outcomes often lie outside the healthcare system. However, current governance structures and policy frameworks are not designed to enable integrated, place-based preventive health responses that reflect the complex and intersecting needs of communities.

As previously described, the division of governance, regulation, and funding between federal and state governments, and further still between sectors and professions, has created a highly fragmented system.

This disconnect makes it difficult to align investments, share data, or coordinate service delivery in ways that respond holistically to the health needs of people and communities. Without strong mechanisms to support shared governance, joint planning, and transparency and accountability across sectors and levels of government, opportunities to use preventive care to drive the outcomes that matter are unable to be embedded into business-as-usual activity.

Ultimately however, underpinning these identified barriers to effective investment in preventive care, straining under immense pressure to meet escalating acute demand - let alone having the capacity to anticipate and prepare for future health needs.

In this context, the system is being forced into reactive, short-term responses that prioritises throughput and immediate risk mitigation over long-term health outcomes. Prevention, which by nature requires sustained investment, intersectoral collaboration, and a future-oriented mindset, is challenged to maintain meaningful public and government attention and investment in competition to a system struggling to manage current business-as-usual practice.

A challenge of this magnitude calls for more than piecemeal investment in prevention programs. It demands a coordinated, system-wide approach, one that rethinks how care is managed, funded, delivered, and experienced.

Q. What are some examples of successful prevention programs (this could include discontinued programs)?

In the current climate of a health system under pressure, there is little room left for experimentation, innovation, or the kind of structural reform needed to embed prevention as a core function across all levels of the health system. As a result, where promising models of preventive and community-based care are developed and piloted (often out of necessity), their scale and spread into systemic adoption is frequently undermined by poor resourcing, competitive acute funding opportunities for government investment, or inability to maintain concentration against emerging threats.

AHHA proposes that, in the absence of a health system reform agenda, what is needed is an independent online clearinghouse that houses case studies of innovative primary and community models of care. This repository could provide health system leaders with clear, actionable information on programs that are driving improvements in outcomes, along with advice and information about contextual-relevance, research, and evidence-based practice that could support the translation of what would be decades of research and pilots into system-wide, scalable reform opportunities.

The clearinghouse should be structured to align with the direction being set through the new **Health System Performance Assessment Framework** being developed by the AIHW, which in its draft outlines:

- Supporting a '*shared stewardship of a learning health system*'
- Being '*primarily a tool to support policy action, [with] its main audience [as] health leaders who are responsible for and have influence over system-level decision-making*'

As a framework to preventive investment, such an approach will require a wider reflection on the current structure and effectiveness of the healthcare system, even without an active reform agenda.

AHHA would be happy to discuss any further aspects of this proposed approach.

Q. How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?

While a clearinghouse approach offers both a reprise to the current strain on scale and spread of innovative preventive care, and an opportunity to deliver better care more efficiently, tinkering around the edges of health system reform will not deliver the sustainability and resilience the system urgently needs.

Instead, achieving meaningful investment in prevention to realise the long-term benefits in outcomes and cost-savings demands an agenda that goes beyond the iterative, siloed approach we have accepted within the constraints of our current health system structure. Rather, achieving a healthy Australia supported by the best possible health system requires:

- Funding that is sustainable and appropriate to support a high quality health system,
- Performance information and reporting that is fit-for-purpose,
- An integrated health workforce that exists to serve and meet population health needs, and
- A nationally unified, regionally controlled system that puts people at the centre[22].

AHHA would like to draw your attention to our *Blueprint for outcomes-focused, value-based health care*, where a series of short-, medium- and long-term actions to drive these objectives is outlined in detail. Alongside the swathe of recommendations derived from system reviews undertaken in recent years (e.g., Mid-Term Review of the NHRA[23], Working Better for Medicare[24], Unleashing the Potential of Our Health System[25]), the Blueprint could serve as a foundation for aligning reform opportunities.

Realising a healthier Australia requires a deliberate shift toward coordinated, long-term system reform grounded in the evidence, expertise, and views from across the system.

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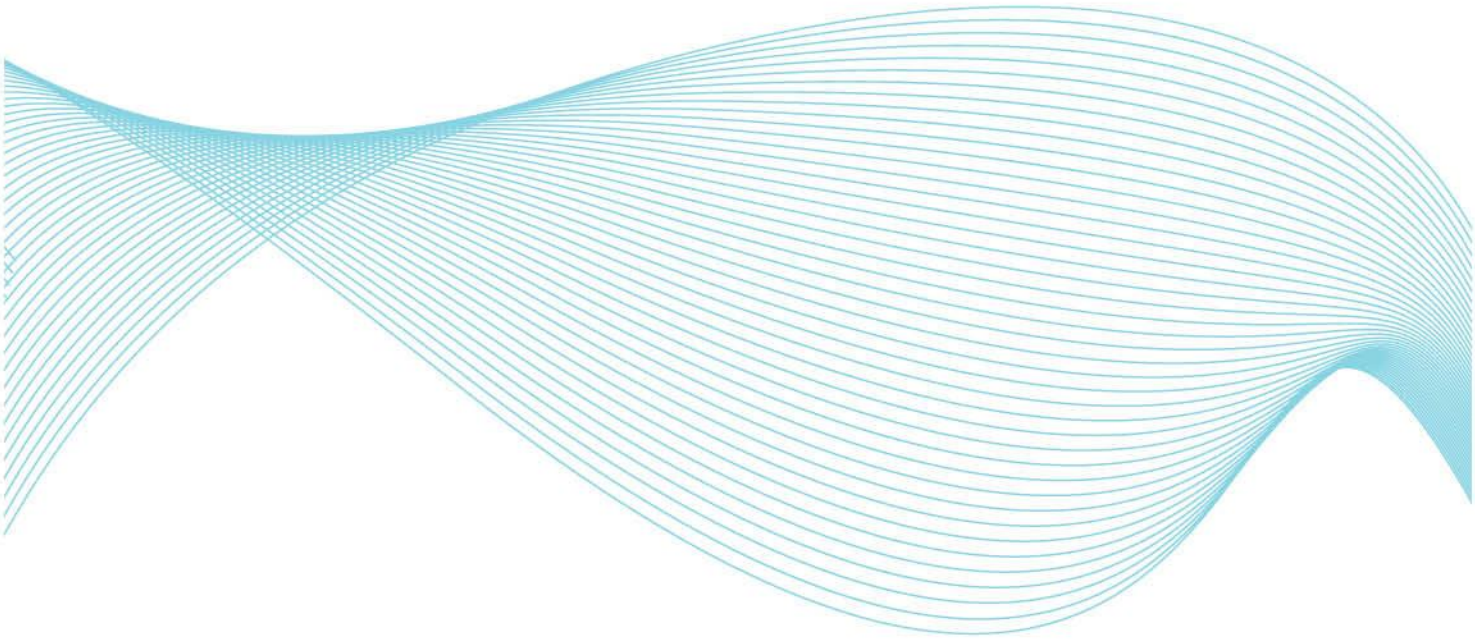

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