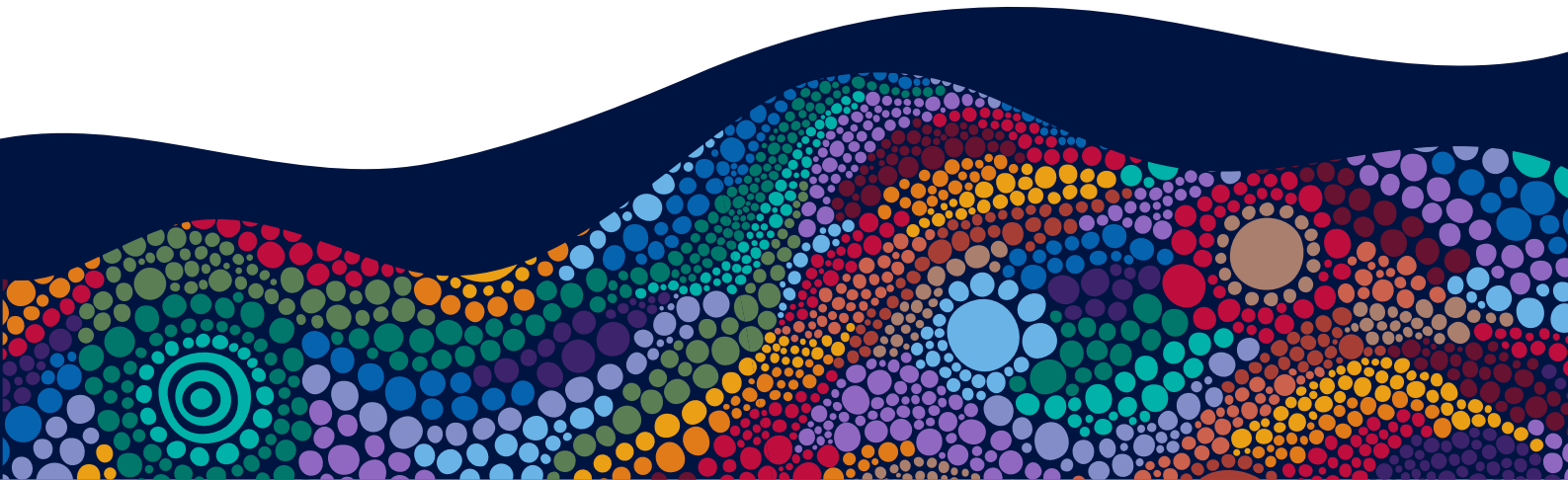
NACCHO
National Aboriginal Community Controlled Health Organisation

5 Pillars consultation

Submission to Productivity Commission

July 2025



About NACCHO

NACCHO is the national peak body representing 146 Aboriginal Community Controlled Health Organisations (ACCHOs). We also assist a number of other community-controlled organisations.

The first Aboriginal medical service was established at Redfern in 1971 as a response to the urgent need to provide decent, accessible health services for the largely medically uninsured Aboriginal population of Redfern. The mainstream was not working. So it was, that over fifty years ago, Aboriginal people took control and designed and delivered their own model of health care. Similar Aboriginal medical services quickly sprung up around the country. In 1974, a national representative body was formed to represent these Aboriginal medical services at the national level. This has grown into what NACCHO is today. All this predated Medibank in 1975.

NACCHO liaises with its membership, and the eight state/territory affiliates, governments, and other organisations on Aboriginal and Torres Strait Islander health and wellbeing policy and planning issues and advocacy relating to health service delivery, health information, research, public health, health financing and health programs.

ACCHOs range from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services which rely on Aboriginal health practitioners and/or nurses to provide the bulk of primary health care services. Our 146 members provide services from about 550 clinics. Our sector provides over 3.1 million episodes of care per year for over 410,000 people across Australia, which includes about one million episodes of care in very remote regions.

ACCHOs contribute to improving Aboriginal and Torres Strait Islander health and wellbeing through the provision of comprehensive primary health care, and by integrating and coordinating care and services. Many provide home and site visits; medical, public health and health promotion services; allied health; nursing services; assistance with making appointments and transport; help accessing childcare or dealing with the justice system; drug and alcohol services; and help with income support. Our services build ongoing relationships to give continuity of care so that chronic conditions are managed, and preventative health care is targeted. Through local engagement and a proven service delivery model, our clients 'stick'. Clearly, the cultural safety in which we provide our services is a key factor of our success.

ACCHOs are also closing the employment gap. Collectively, we employ about 7,000 staff – 54 per cent of whom are Aboriginal or Torres Strait Islanders – which makes us the third largest employer of Aboriginal or Torres Strait people in the country.

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Acknowledgements

NACCHO welcomes the opportunity to provide a submission to Pillar 2: Building a skilled and adaptable workforce questionnaire.

NACCHO supports the submissions to this consultation made by NACCHO Members and Affiliates.

NACCHO also welcomes the opportunity to participate in further consultation with the delivery of the Interim Report in August 2025.

National Agreement on Closing the Gap

At the meeting of National Cabinet in early February 2023, First Ministers agreed to renew their commitment to Closing the Gap by re-signing the National Agreement, first signed in July 2020. The reforms and targets outlined in the National Agreement seek to overcome the inequality experienced by Aboriginal and Torres Strait Islander people and achieve life outcomes equal to all Australians.

This Government's first Closing the Gap Implementation Plan commits to achieving Closing the Gap targets *through implementation of the Priority Reforms*. This represents a shift away from focussing on the Targets, towards the structural changes that the Priority Reforms require, and which are more likely to achieve meaningful outcomes for our people in the long term.

Priority Reform Area 1 – Formal partnerships and shared decision-making

This Priority Reform commits to building and strengthening structures that empower Aboriginal and Torres Strait Islander people to share decision-making authority with governments to accelerate policy and place-based progress against Closing the Gap.

Priority Reform Area 2 – Building the community-controlled sector

This Priority Reform commits to building Aboriginal and Torres Strait Islander community-controlled sectors to deliver services to support Closing the Gap. In recognition that Aboriginal and Torres Strait Islander community-controlled services are better for Aboriginal and Torres Strait Islander people, achieve better results, employ more Aboriginal and Torres Strait Islander people and are often preferred over mainstream services.

Priority Reform Area 3 – Transformation of mainstream institutions

This Priority Reform commits to systemic and structural transformation of mainstream government organisations to improve to identify and eliminate racism, embed and practice cultural safety, deliver services in partnership with Aboriginal and Torres Strait Islander people, support truth telling about agencies' history with Aboriginal and Torres Strait Islander people, and engage fully and transparently with Aboriginal and Torres Strait Islander people when programs are being changed.

Priority Reform Area 4 – Sharing data and information to support decision making

This Priority Reform commits to shared access to location-specific data and information (data sovereignty) to inform local-decision making and support Aboriginal and Torres Strait Islander communities and organisations to support the achievement of the first three Priority Reforms.

Review of Closing the Gap

In its first review of the National Agreement on Closing the Gap, the Productivity Commission found that governments are not adequately delivering on their commitments. Despite support for the Priority Reforms and some good practice, progress has been slow, uncoordinated, and piecemeal.

The Commission noted that to enable better outcomes, the Australian government needs to relinquish some control and acknowledge that Aboriginal and Torres Strait Islander people know what is best for their communities. It needs to share decision making with Aboriginal Community Controlled Organisations (ACCOs), recognise them as critical partners rather than passive funding recipients, and then trust them to design, deliver and measure government services in ways that are culturally safe and meaningful for their communities.

'Too many government agencies are implementing versions of shared decision-making that involve consulting with Aboriginal and Torres Strait Islander people on a pre-determined solution, rather than collaborating on the problem and co-designing a solution'[1]

NACCHO recommends all productivity measures align with the National Agreement and its four Priority Reform Areas.

[1] Productivity Commission, Review of the National Agreement on Closing the Gap, Study Report, Canberra, 7 Feb 2024 https://www.pc.gov.au/inquiries/completed/closing-the-gap-review/report.

Pillar 2

Question 1a | In your experience, how well does the credit transfer and recognition of prior learning system operate in Australia? Does it adequately support students to move between courses or have their work experience recognised as part of a qualification?

In NACCHO's experience, the credit transfer and recognition of prior learning system does not operate adequately to support students to move between courses or have their experience recognised as part of the qualification they are undertaking. NACCHO's member services largely operate as multi-disciplinary teams, ranging across not only primary health care but also aged care and disability. The ability for staff to upskill, have existing skills recognised or be supported to move across disciplines is critical for workforce development and retention in the sector.

However, the structure of the VET system and funding models, and the consistent turnover of training packages means that smaller Aboriginal Community Controlled Registered Training Organisations (ACCRTOs) often struggle to ensure their resources and assessment guides remain industry relevant. Moreover, the ASQA regulatory environment is complex and incurs a high administrative burden which ACCRTOs are not funded for yet are required to remain compliant. This hinders innovative approaches to how RPL processes can be leveraged in a way that meets industry needs.

There is no requirement for RTOs to offer students RPL for previous experience, indeed delivery of RPL is often inadequately funded, or not funded at all, meaning out of pocket costs for RTOs. We know that RTOs often encouraging students to undertake the full qualification rather than seek RPL, which in part is encouraged due to the funding streams. Approaches to RPL, where they exist are heavily reliant on the student gathering hardcopy evidence of qualifications and experience, a process that can discourage even the most enthusiastic.

Participants in NACCHO's First Nations Health Worker Traineeship Program report that changing qualification requirements has seen students lose previously awarded RPL credit. This creates additional barriers for students who may have already completed the remainder of the qualification and who were reliant on this RPL for final sign off.

In addition, there are no standardised or consistent approaches to how RPL is applied across a qualification or industry. In contrast, the credit transfer process is simplified using a student's Unique Student Identifier (USI) transcripts. The ability to seek RPL between VET and university qualifications is also severely limited, creating further barriers for workers looking to upskill.

Question 1b | Are there ways it could be improved?

Credit transfer & RPL are essential elements of the Aboriginal and Torres Strait Islander Health and Care Traineeship Framework developed by NACCHO. In partnership with the ACCHRTO sector and the Human Skills Services Organisation (HSSO), NACCHO have designed an RPL Toolkit for a number of core units in the HLT Aboriginal and/or Torres Strait Islander Primary Health Care training package. This toolkit provides participating ACCHRTOs with a consistent approach to applying RPL.

There are a number of principles from the Framework that could be applied across the VET training sector to ensure that all students are able to access training and have previous skills, experience recognised prior to undertaking a full qualification ensure that the student is at the centre of the model and is geared towards empowering them and supporting them to succeed including through qualifications being broken into skill sets which can be built upon leading to formal qualifications and moving into career specialisation pathways.

For Aboriginal and Torres Strait Islander students it is critical to ensure that cultural safety is embedded into these tools. The centrality of culture to health and wellbeing is a principle that Aboriginal and Torres Strait Islander peoples have lived for thousands of years. The National Agreement on Closing the Gap provides a definition of 'cultural safety' which highlights that this is not just locally contextualised, but also specific to each individual.

Pathways may be structured or a series of less structured jobs and education experiences that help people acquire the skills, knowledge, and experience necessary to enter or progress within the workforce. These pathways aim to align a person's interests and aspirations with relevant career opportunities while addressing the needs of employers, and in the case of some occupations, regulators.

Workforce development pathways identify and highlight the systematic and holistic approaches available for a person to acquire the necessary skills, education, experience, and support to achieve their career goals. This approach emphasises the importance of personal and professional growth, adaptability, and lifelong learning.

- ***Skills Assessment***
  To gain an understanding of a person's existing skills, knowledge, experience, aptitudes, and interests. Evaluation and identification of existing strengths and areas for improvement can help guide a person toward possible career options. Recognition of Prior Learning (RPL) is a fundamental component.
- ***Career Exploration***
  The concept of development pathways emphasises the importance of career exploration to allow people to understand different job roles, and potential growth opportunities. This exploration may involve job shadowing, conversations with colleagues, work placement or internships, enabling people to make informed decisions about their interest and suitability for future career paths.
- ***Industry-Recognised Credentials***
  Many pathways offer the opportunity to earn industry-recognised credentials or certifications. These credentials validate a person's skills and competence in a particular field, enhancing their employability and demonstrating their commitment to professional development.
- ***Guidance***
  Support or guidance from experienced professionals play a vital role in workforce development pathways.
- ***Work-Based Learning***
  The best development pathways include work-based learning experiences,. These experiences allow a person to apply their knowledge in real-world settings, gain practical experience, and establish valuable connections within the industry.
- ***Career Advancement***
  Workforce development pathways address not only entry-level positions but also opportunities for career advancement. They provide people with a clear roadmap for progressing within their chosen field, outlining the skills, experience, and additional training required to move up the career ladder.
- ***Lifelong Learning***
  The concept of workforce development pathways emphasises the importance of continuous learning and adaptability. In today's rapidly changing job market, people are encouraged to embrace lifelong learning, acquire new skills, and stay updated with emerging trends and technologies. This approach also encourages employers to consider the ongoing development needs their existing workforce. Including but not limited to refresher training, skills-gap training and continuous professional development

Question 2 | What are the main reasons individuals and/or businesses do or do not participate in work-related training?

Work-related training is a pivotal requirement across the ACCHO sector. Currently, it is delivered both formally and informally. Informally, this is from one staff member to another in the completion of a specific task, to upskill workforce quickly, or in lieu of the availability of formal training. Formal training occurs predominately through VET courses, led by the ACCRTO sector where available. In jurisdictions with limited access to the ACCRTO sector, the TAFE sector.

Barriers for the ACCHO sector to access work relate training include:

- Inadequate funding
- remoteness means limited local/regional opportunities for in-person place based training, or additional time and costs associated with travel to undertake training

- workforce shortages impact the ability to backfill positions and release staff for training without impacting service delivery
- lack of paid training opportunities for workers
- limitations to online delivery for clinical requirements where in person training is more effective
- time and cost
- ongoing CPD requirements and regulatory training requirements may limit the ability to access other training opportunities
- limited training workforce, for example qualified VET facilitators
- ACCRTOs severely underfunded which limits scope of delivery and capacity to expand. This has resulted in the sector being unable to meet the rapidly growing workforce needs of the ACCHO/ACCO sector as they expand into human service front line delivery for example.
- lack of cultural safety in training materials, providers or training environment when working with mainstream providers

The instability of funding models in the ACCHO and ACCRTO sector create barriers for workforce development. Access to long-term, consistent funding which supports workforce training needs development would assist ACCHOs to plan and invest in work-related training solutions. Higher local productivity would also occur due to the preference of ACCHOs to build a local workforce.

Peak bodies and employers have a role to play in designing work related training including online and face to face options and working with RTOs to design such courses. The FNHWTP program led by NACCHO demonstrates the efficacy of this approach and the cost efficiencies made through scalability measures.

Question 3 | What role, if any, should businesses be playing to address any barriers and better support the offer of work-related training to employees?

Employers and industry have a central role to play, in partnership with the RTO sector, in the success of work-related training offered to employees. This is especially critical for the ACCHO sector, due to clinical supervisory placement requirements. Governments play a vital role in ensuring work-related training options are enabled, accessible and funded.

Training needs to be responsive to industry needs, support career progression and worker retention. For Aboriginal participants, businesses play a critical role in supporting not only the training delivery requirements (such as having time off work to attend training) but also providing ongoing support in the workplace to ensure participants are able to balance family, cultural and social responsibilities.

Businesses also play a role in working in partnership with RTOs to ensure the training addresses the skills and knowledge required to successfully and confidently undertake the required work. A national Training Needs Analysis (TNA) with employers is required to assist with a targeted training skill-set, rather than sole focus on full qualifications, that meets industry needs.

Moving employers away from in-house unaccredited training options currently used within organisations is encouraged to ensure transferability of skills for workers is recognised, thus reducing duplication in future workplace training.

NACCHO recommends

- a mandatory requirement for RTOs to offer RPL processes to all students, noting the funding barriers must be addressed for this to be successful
- a workforce pathway model to be adopted to ensure recognition of student's prior experience and skills
- a national TNA of businesses/industry to identify the skills and knowledge required for the workforce, which then flows to identification of national skill sets.
- flexible pathways including utilisation of RPL and support for workers entering or returning to their chosen sector including pathways between VET and university qualifications

Pillar 4

Question 4 | We are seeking responses to questions on three policy reform areas. Which policy reform areas would you like to respond to?

- Reform of quality and safety regulation to support a more cohesive care economy
- Embed collaborative commissioning to increase the integration of care services
- A national framework to support government investment in prevention

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Question 5 | To what extent do differences in quality and safety regulation make it costly or complex to provide or access care services?

- To a great extent

Question 6 | What are the reasons for your answer?

Greater coordination and sharing of data across government departments and agencies is critical, as is simplification and integration of front-end systems and processes. Government must make it easier for people access and navigate the supports they need without having to understand government funding systems or processes to do so. The regulatory system must be streamlined and integrated.

ACCHOs are funded by the Commonwealth government to provide primary healthcare and are already required to comply with a range of standards, including the National Health Standards, RACGP Standards and ISO standards. Yet, ACCHOs are unable to use their clinical governance frameworks in registering to deliver either aged, disability or veterans' care. Not only does this mean longer registration timeframes and costs, but the inability also to leverage existing registration in delivery of other care services means duplicative systems and processes must be created. Each of which deals with largely similar data and information.

Moreover, due to the poor alignment of regulatory systems between disability, aged care and primary healthcare, many ACCHOs are overburdened with maintaining regulatory requirements. The burden of reporting and compliance across multiple systems is significant and the additional staffing needed to manage separate processes is generally not funded.

Front end processes from entry to compliance must be simplified for providers and data shared between departments and agencies as necessary. This is a large barrier to ACCHOs delivering care services in addition to primary healthcare.

Question 7 | To what extent should quality and safety regulations be more aligned across the different care service sectors and jurisdictions?

- To a great extent

Question 8 | What are the reasons for your answer? (250 words)

Regulation is vital to ensuring Aboriginal and Torres Strait islander people receive culturally safe and quality care. The commonalities across care sector regulatory systems lend themselves to integration, rather than alignment. A single regulatory system would increase service level productivity while still ensure standards for quality care were met. A single regulatory system would support more collaborative ways of working across government departments and agencies.

Significant benefits for Aboriginal and Torres Strait Islander people can be gained from a single set of aged, disability and veterans' care regulations. Consolidated regulations should align with the priorities of the National Agreement for Closing the Gap (National Agreement), and should be streamlined across jurisdictions. The benefits of a single system are multiple:

- ***Registration***

  Common registration requirements create greater synergies for screening processes, registration costs

and breaks down barriers where workforce is in high demand but short supply.

- ***Administrative burden***

  Feedback from our members highlight the high administrative and cost burden to ensure all reporting and auditing requirements are met across multiple registrations. A single regulatory system would improve efficiency and free staff for other work.

- ***Continuity of care***

  Common regulations will assist in breaking down jurisdictional requirements where a person may need to access care services across state/territory borders, supporting consistency of care standards across jurisdictions.

- ***Cultural safety***

  Alignment of care sector regulations should also see the incorporation of cultural safety requirements such as those included in Aged Care sector reforms.

- ***Workforce training pathways***

  Harmonising regulatory environments helps to embed training pathways for people to change to focus of their career, for example an Aboriginal and Torres Strait Islander Health Worker moving into aged or disability care, or vice versa.

Question 9 | What is your experience with collaborative commissioning?

The Aboriginal Community Controlled Health sector has been involved in collaborative commissioning initiatives with Primary Health Networks (PHNs) to deliver and co-design services. As always, the focus for ACCHOs is on ensuring that services are culturally safe and appropriate for Aboriginal and Torres Strait Islander communities.

Feedback from NACCHO member services suggests that PHNs often do not have the skills to engage with, commission or deliver services for Aboriginal and Torres Strait Islander communities. It has been the experience of our ACCHOs that there is a widespread reticence of PHNs to engage with external organisations generally – not just with ACCHOs.

In practice, when funding is provided to ACCHOs through PHN commissioning arrangements, its value is often diminished due to complex reporting arrangements with often short submission timelines, lack of flexibility in how the funding can be utilised, and instances of funding being tied to programs that are culturally inappropriate for the intended community. This often leaves ACCHOs to fill the funding gap, address the unfunded reporting overheads and undertake resource intensive adaptation of programs to suit local cultural requirements.

Current PHN commissioning approaches often result in significant delays in ACCHO contract renewals. This leads to gaps in funding for salaries between agreements and makes it difficult for ACCHOs to retain staff and impacts service continuity. ACCHOs report issues with staff leaving to join mainstream services as they can offer more stability and higher salaries. Understandably, this has a negative impact on outcomes for ACCHOs and for the Aboriginal and Torres Strait Islander communities they support.

Funding delivered through Primary Health Networks (PHNs) and mainstream peak bodies is not aligned with the Priority Reforms, nor are funded agencies being held appropriately accountable to the Priority Reforms as part of their contractual obligations. The PHN Approach to Market for services to Aboriginal and Torres Strait Islander people is not informed by the National Agreement and fails to consider the important role that ACCHOs and peak bodies play in the Aboriginal and Torres Strait Islander health landscape. One Affiliate described, *the over-engineering of grant guidelines to the point of inaccessibility, ignoring expertise or reinterpreting it through grant teams*. Stronger mechanisms, including explicit alignment with the Priority Reforms as part of contractual requirements are needed to ensure transparency of funding identified for Aboriginal and Torres Strait Islander communities.

Under Priority Reform 3 of the National Agreement, PHNs as commissioning bodies for government services are responsible to deliver systematic and structural transformation, to improve accountability and respond to the specific needs of Aboriginal and Torres Strait Islander people.

Question 10 | What are the benefits of pursuing greater collaborative commissioning?

A 2023 paper by the NDIA suggests that government has taken a largely 'hands off' approach to market stewardship.[2] The report states,

> *The NDIA has been using a 'least interventionist approach' to achieve a better functioning and sustainable market, while recognising some thin markets may require several market interventions to be delivered iteratively over a long term. This approach, however, reflects a more rigid and time-limited application of a stewardship framework more suited to private sector markets.*
>
> It goes on, *Evidence from past and ongoing reviews and inquiries continues to show that the current market-based model with individualised funding arrangements persistently fail to meet the needs of both First Nations and remote communities.*

This is a failure of the insistence on an individualistic, market-led service delivery approach rather than one focussed on the health and wellbeing outcomes of participants. Yet, despite the recommendations of multiple reviews since 2017 (outlined in the above paper), there remains a reluctance to provide block funding for the delivery of care services. A mixed model approach would be more effective and sustainable for community controlled providers.

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.

In contrast to PHN commissioning practices, ACCHOs report that 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.

In October 2021, the House of Representatives Select Committee on Mental Health and Suicide Prevention Final Report recommended that the Australian Government:

- consolidate its funding portfolios to Aboriginal Community Controlled Health Organisations (ACCHOs) within the Department of Health for Aboriginal mental health, suicide prevention, and social and emotional wellbeing, and
- ensure that Commonwealth funding for Aboriginal services is redirected from Primary Health Networks to ACCHOs, where available.

Although these recommendations are related to mental health and suicide prevention, in combination with overwhelming evidence from other sources, they suggest this is the necessary path forward across the board.

Question 11 | 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 services?

It is critical, that accountability measures are embedded in funding agreements to require ongoing, sustainable and embedded engagement and co-design with communities. Accountability measures should also ensure funds earmarked for Aboriginal and Torres Strait Islander people prioritise delivery through community controlled services.

While PHN Guiding Principles for working with ACCHOs have been in place since March 2016, there is no obligation for PHNs to use them. The Principles must be updated to align with the National Agreement on Closing the Gap. PHNs and LHNs must be held accountable through funding agreements for ensuring the delivery of culturally safe care to Aboriginal and Torres Strait Islander communities, through their commissioning arrangements.

In line with Action Area C in the Primary Health Care 10 year Plan, PHN funding intended to benefit Aboriginal and Torres Strait Islander communities should be transitioned to the ACCHO sector. In addition,

[2] Australian Government, NDIS Review, Alternative commissioning for remote and First Nations communities, May 2023

Aboriginal and Torres Strait Islander community-led commissioning models for urban, rural and remote areas should be scoped and trialled.[3]

Under the First Nations Health Funding Transition Program, the Department of Health and Aged Care in partnership with NACCHO and other key peaks, has identified 32 Aboriginal and Torres Strait Islander health programs, that would be better delivered by Aboriginal and Torres Strait Islander community-controlled organisations.

The Productivity Commission Review of Closing the Gap report[4] also noted that changes to commissioning processes and contracting could ensure that only service providers with the capability to provide culturally safe services are selected.

Question 12 | What are the main barriers to governments investing in evidence-based prevention programs across the care economy?

The long term health, social and productivity benefits of preventive approaches to health and care are well documented. Preventive and public health interventions yield high return on investment of $14 for every dollar invested[5]. Australia's health system is based on illness management rather than illness prevention. There is a lack of long-term vision and political will to implement the changes needed to refocus health systems toward primordial and primary prevention.

Concerted and consistent action on determinants of health (primordial prevention) would have wide ranging benefits for Aboriginal and Torres Strait Islander people. The evidence demonstrating the powerful links between housing and outcomes for health is abundant, 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.

Australia must invest 5% of the health budget in preventive health and establish a Centre for Disease Control. This investment must include health peak bodies, public health and the health workforce to support preventive and public health for all, especially priority populations. Preventive health is key to circumvent disease and address health inequity.

Question 13 | What are some examples of successful prevention programs (this could include discontinued programs)?

An additional barrier to preventive approaches is the insistence of governments on funding only new and 'innovative' programs, rather than expanding or continuing to fund programs that demonstrate strong outcomes. Successful prevention programs are often defunded which means any progress made is lost rather than consolidated through continued funding.

The ACCHO model of care is based around preventative primary health care practice, initiatives including healthy lifestyle, immunisations, cancer, and accessibility programs. However, ACCHOs are not funded for this work under the IAHP – much of this work is funded by ACCHOs.

Question 14 | How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?

Governments should continue to fund programs that demonstrate strong outcomes for communities. Short term funding cycles undermine good progress and diminish community trust in government. Entrenched issues require long term investment, not a status quo or band-aid approach.

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[3] Primary Health Care 10 Year Plan 2022-2032, Action area C: Close the Gap through a stronger community controlled sector, https://www.health.gov.au/resources/publications/australias-primary-health-care-10-year-plan-2022-2032?language=en.

[4] Productivity Commission, Review of the National Agreement on Closing the Gap – Study report: Volume 1, Jan 2024, https://www.pc.gov.au/inquiries/completed/closing-the-gap-review/report/closing-the-gap-review-report.pdf

[5] Masters, R., Anwar, E., Collins, B., Cookson, R., Capewell, S. (2017) Return on investment of public health interventions: a systematic review. J Epidemiol Community Health, 71(8), 827-834. doi:10.1136/jech-2016-208141.

Block funding models that seek outcomes rather than activities support community-led approaches which we know deliver better results. Fee for service models are at odds with the ACCHO Model of Care and rarely work for the sector, for example the NDIS.

Investment in local economies is critical. This requires changes to tender processes to prioritise local organisations who are currently excluded due to the complexity of process due and their inability to compete with large companies. Where services such as housing maintenance are outsourced, companies must be required to invest in training local staff to deliver in regional, rural and remote areas, rather than utilising FIFO models of delivery. This creates local job and economic opportunities, and means better access to services for local people.

Sustained investment in primordial prevention is critical, as is commitment to implementation of the Priority Reforms of the National Agreement. The structural changes engendered by embedding the Priority Reforms across the health system will have significant impact on health outcomes.

NACCHO recommends

- a single regulatory system across disability support, aged care and primary healthcare
- Commonwealth funding for Aboriginal and Torres Strait Islander services is redirected from Primary Health Networks to the ACCHO sector.
- PHNs and other funded organisations be held accountable in their funding agreements to delivering against the Priority Reforms, and that penalties are applied for not achieving those KPIs.
- PHNs be contractually required to prioritise community controlled service providers for funding identified for Aboriginal and Torres Strait Islander communities.
- Government prioritise systemic change toward preventive models of care, including a focus on primordial prevention and addressing determinants of health.
- Government continue to fund health, care and wellbeing programs that work
- Government ensure tender processes prioritise or require investment in local communities, including ensuring training and skills development for local people.