Submission by the Australian Nursing and Midwifery Federation

ANMF Submission to the Productivity Commission: Delivering Quality Care More Efficiently Interim Report

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Australian Nursing & Midwifery Federation

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Introduction

1. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial, and political interests of more than 345,000 nurses, midwives, and care-workers across the country.

2. Our members work in the public and private health, aged care, and disability sectors across a wide variety of urban, rural, and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals, and achieve a healthy work/life balance.

3. Our strong and growing membership and integrated role as both a trade union and professional organisation provides us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

4. Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

5. The ANMF thanks the Productivity Commission for the opportunity to provide feedback on the Delivering Quality Care More Efficiently Interim Report (the Interim Report).

Overview

6. Enhancing the efficiency of care across the health and care sectors is an important endeavour, however efforts to this end must never be prioritised above the need to deliver high quality, accessible care, nor should they compromise the health, safety, or wellbeing of the workforce delivering that care.

7. In the health care sector, productivity is contingent on quality of care and value in terms of outcomes and experiences, time, education and expertise, bedside manner, and affordability. As previously stated by the Productivity Commission, this is not about making the workforce work harder, but about '*making the most of what we have*' in terms of the workforces' skills and experience and their ability to harness both existing resources and technologies and new innovations and ways of working. This includes enabling staff to work to their full potential in effective teams and roles by investing in addressing barriers to staff working to their full scope of practice as well as implementation and adoption of models of care that utilise staff's full scope of practice effectively with clear job roles, delegation frameworks, and supervision.

8. Productivity is also inseparable from staff outcomes and experiences including safety, wellbeing, and satisfaction and having the time and support to provide safe, dignified, and quality care. This requires a suitably sized and skilled workforce. For efficiency reforms to succeed, governments must first invest in addressing ongoing critical workforce shortages and challenges across the health and related sectors. This includes investment in high quality, accessible, and affordable education and training including secondary and tertiary education and continuing professional development to address the pipeline of new workers and support ongoing skills development.

9. Retention of the existing healthcare workforce is of principal importance and therefore most importantly, investment and action must be taken to improve working conditions and strengthening both physical and psychosocial safety to sustain and support the existing and future workforce. These factors relate to strategies to address staff wellbeing, burnout,

attrition, retention, and recruitment, which are fundamental issues underpinning the maintenance of a sufficiently sized, skilled, and healthy workforce. Without taking these factors into serious consideration and acting upon them, reforms to enhance efficiency risk amplifying workforce shortages, compromising care quality, and ultimately undermining both sector productivity and the standard of care delivered to the community. Strategies include better gender-equal pay, better working conditions and safety, flexible rostering and leave, permanent positions, workforce health, wellbeing, and support, and staff performance and career development.

10. One critical issue that appears absent from the Interim Report is how private profit derived from public funding shapes productivity and quality in the health care sector. While the report discusses improving 'efficiency' and 'value for money,' it assumes provider incentives are neutral. In practice, for-profit providers in health, aged care, and disability services are driven by maximising shareholder returns. These providers receive substantial government funding, resources, however, are often diverted into activities such as portfolio diversification (e.g., real estate acquisitions, particularly notable in aged care) and executive salaries, rather than being used to improve staffing levels, workforce pay, or service quality. If productivity in the care sector is understood as delivering more and better outcomes per dollar spent, then ownership models must be scrutinised. Reforms that do not take this into consideration risk entrenching inefficiencies and driving up costs that ultimately results in less care for more money.

11. The ANMF cautions against attempts to increase or measure productivity gains in terms of patient throughput or hospital profit margins, as these frequently come at the expense of care quality. This is particularly evident in private hospitals, where profit-driven models are often linked to higher rates of adverse events and poorer patient outcomes. Similarly, policies that increase privatisation and marketisation, which are promoted as pathways to greater efficiency and quality of care, frequently result in the reverse, such as higher consumer costs and diminished quality of care. While this has not been addressed in the Interim Report, the ANMF strongly advises that the Commission and Government do not

consider any productivity reforms that promote increased privatisation, marketisation, or patient throughput.

12. As nurses, midwives, and personal care workers comprise the largest proportion of the health workforce, any reforms proposed by the Commission will likely have a direct impact on their practice, workplace conditions and wellbeing and therefore the quality and efficiency of care delivered to the community. The Commission and Government must meaningfully engage with frontline care workers in the development and implementation of any and all recommendations.

Reform of quality and safety regulation

13. The ANMF expresses concern with the Commission's recommendations regarding regulatory alignment across the aged care, NDIS, veterans' care, and early childhood education and care sectors. While recognising that there are some commonalities across these professions, the Commission must acknowledge the distinct operational, professional, and care needs within each sector. For example, in the development of a standardised quality and safety reporting framework and indicators, it must be recognised that 'safety' and 'quality' have different operational indicators across sectors, dependent on the care needs of the those receiving care within each sector. Imposing a uniform framework risks producing measures that are too generic to capture sector-specific challenges, or that fail to meaningfully improve outcomes for care recipients.

14. The ANMF broadly supports the Commission's recommendation to establish a single national worker screening clearance. The current decentralised and fragmented system creates inefficiencies and delays in workforce onboarding, often resulting in loss of income for workers and broader disruptions to health care service delivery. While a single, streamlined check would help reduce these inefficiencies, it is essential that the clearance process maintains a sufficiently robust standard to ensure community confidence and trust in the care workforce.

15. The ANMF is supportive of the Commission's recommendation to adopt a unified approach to worker registration across aged care, NDIS, and veterans' care. While the Interim Report *did not* examine whether the Australian Government should mandate registration in these sectors, the ANMF is supportive of the establishment of a national positive registration scheme managed by Ahpra. Given that many work across all three sectors, a single registration framework would reduce administrative burdens for worker and providers, and the establishment of a minimum standard would strengthen the quality and safety of care. Further, this would ensure that unregistered care workers are formally recognised, valued, and supported, and have access to professional development opportunities and improved working conditions.

16. While the ANMF acknowledges the principle of mutual recognition of audits as a means to streamline compliance processes and reduce administrative burden, as previously mentioned differences between the sectors must be recognised, and the establishment of a common suitability test across sectors should not reduce the rigor of assessments required by providers to be deemed suitable to provide care across the sectors.

17. The ANMF broadly supports elements of streamlining reporting requirements across aged care, NDIS, and veterans' care, as current duplication drains workforce and provider resources that should be directed to patient care. The single national reporting portal must be fully cognisant of the need to manage definition and practical differences between notions of safety and quality across these similar but very distinct sectors. Further, the portal must be underpinned by consistent, evidence-based indicators, with strong protections for workers' and residents' safety. Public reporting should focus on transparency and accountability that drives quality improvement, not punitive or lip-service compliance alone.

18. The ANMF broadly supports the Commission's recommendation to develop a consistent approach to the regulation of artificial intelligence (AI) across the aged care, NDIS and veterans' care sectors. We note however that this position has not been adopted by the

Commission in its interim reports in other inquiries being run concurrently with this one, such as the interim report into harnessing data and digital technology. For clarity, the ANMF is broadly supportive of the regulation around the ethical and safe use of AI across all industries and occupations, not just those identified in this inquiry.

19. The ANMF is of the view that the implementation of AI systems into workplaces should be accompanied by robust consultation rights beyond those provided in the modern award system. Most workplaces operate under an industrial instrument (either a modern award or an enterprise agreement) whereby the right for workers to be consulted about major change is only enlivened when *major* change is proposed, and only *after* a decision has been made to affect that change. The practical implication of this is that workers, who will ultimately be responsible for the use and oversight of AI systems, will have limited opportunity to shape workplace decisions about whether certain AI systems should be implemented in the first place, and if so, how this should be done to ensure quality healthcare while improving workplace efficiency. Also in issue is the possibility that not all workplace changes are considered significant enough to fall into the category of 'major change', for instance where a restructure or job losses are not being contemplated. The ANMF recommends that the Commission consider ways in which worker consultation around the implementation of AI can be improved, namely in ensuring that workers are involved in those discussions *prior* to a decision being made, and that the implementation of an AI system in the workplace should be considered a 'major change' by default, and therefore automatically trigger the employer's obligation to consult.

20. Acknowledging that the Commission's recommendations only included the aged care, NDIS and veterans' care sectors at this stage, the ANMF recommends the establishment of a health sector specific approach to the safe and equitable use of AI. While broader principles, such as *Australia's AI Ethics Principles*, and guidelines, such as the *Voluntary AI Safety Standard guardrails*, have been established, Australia lacks a nationally consistent approach for AI in health care. Health specific safeguarding measures must be developed to ensure systems are designed and maintained to rigorous national and international

standards and are developed in consultation with consumers and key stakeholders to ensure safe, controlled, and effective adoption and integration of AI into healthcare in a way that equitably benefits the Australian community.

21. The ANMF is of the view that the primary purpose of AI in the healthcare sector should be to augment worker capabilities. By contrast, the use of AI for purposes such as worker surveillance or monitoring, and decisions around hiring or disciplinary matters should be expressly prohibited from AI decision making. It is vitally important that both workers and the patients/healthcare recipients can have confidence that AI is only being used to deliver more efficient healthcare with improved health outcomes. Use of AI for intrusive or punitive purposes undermines this objective.

22. Further, noting that the Commission, in the Interim Report, recognises that "*automation needs to be deployed with human oversight to ensure it works as intended*", it is emphasised that human practitioners remain best suited to providing care. The human element of health care (such as responsiveness, assurance, courtesy, empathy, communication, and understanding), must not be replaced by automated systems. While AI in this way may offer cost-savings in the short term, in the long term this will diminish care quality and overall productivity.

Information Request 1.1

For which care services (across aged care, NDIS and veterans' care and beyond) and performance indicators are there the greatest overlap in quality and safety reporting requirements? What are some examples of duplicative reporting requirements across sectors?

23. Across aged care, NDIS, veterans' care, and related sectors, providers are subject to multiple overlapping requirements such as worker screening and registration, provider suitability assessments, audits against quality and practice standards, and incident and quality reporting. While these checks are broadly similar in purpose, they are administered separately, creating duplicated audits, parallel portals, and unnecessary administrative burden, particularly for providers and workers operating across multiple sectors. The

interim report proposes mutual recognition of audits (such as between the aged care and NDIS sectors) and a common provider suitability assessment as fixes, which would be supported by the ANMF.

What should a standardised reporting framework for providers look like? Are there examples of cross-sectoral standardised reporting frameworks that have reduced the reporting burden on providers? How could technology be used to support a standardised reporting framework?

24. A standardised reporting framework should be underpinned by common, modular safety and quality indicators that apply across sectors. This would reduce duplicated reporting while enabling greater comparability and transparency. Such a framework should be supported by a shared data repository and a single digital portal, allowing providers to reuse evidence, facilitate cross-sector analytics, access benchmarking tools, and minimise re-reporting and duplication.

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

25. Information such as performance against common standards, safety and quality indicators, and audit outcomes should be publicly released in a transparent and comparable way. This would support service improvement and innovation as well as transparency and accountability for members of the public, workers, and stakeholders.

Information Request 1.2

What are the costs, benefits and risks of a single quality and safety regulator across aged care, NDIS and veterans' care services?

26. There is merit in considering a single regulator if it reduces duplication, enhances accountability, and applies consistent standards across aged care, NDIS, and veterans' care. However, regulatory arrangements must recognise the distinct needs of different populations (for example, dementia care in aged care compared with disability supports under the NDIS) as well as the interfaces between these systems for both workers and consumers. Any shift towards a single regulator would need to be carefully staged, with genuine consultation and input from the workforce. Importantly, any regulatory

consolidation that weakened safety, reduced oversight, or diluted protections for consumers and workers will be opposed.

27. The benefits of a single regulator could include improved consistency across sectors, reduced duplication of audits and registration, stronger protections for consumers, improved transparency, easier workforce mobility, and more efficient use of resources. Some identified risks could include the potential for key sectoral differences to be overlooked, for consumers' needs to be inadequately accommodated, and challenges such as legislative, IT, and process changes.

To what extent would a single regulator produce a more coordinated, consistent and efficient system, especially if regulation was based on a single set of practice and quality standards and a single provider registration and audit system?

28. A single regulator could improve coordination and efficiency under one set of standards and provider system, provided sector-specific nuances are preserved and considerations of contextual differences and the needs of actors in different sectors are acknowledged and respected. As noted above, however, ensuring that standards in terms of practice and quality are relevant and appropriate across these sectors will be challenging and must be carefully managed.

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

29. If implemented well, a single regulator could improve coordination, consistency, and efficiency by applying one set of standards, a single provider registration process, and one audit system. However, this must be balanced with careful preservation of sector-specific nuances and safeguards. A '*one-size-fits-all*' approach risks creating gaps, reducing effectiveness, and causing unintended harm.

Information Request 1.3

What are the potential benefits and costs of aligning regulatory requirements across aged care and NDIS services for the development of behaviour support plans?

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

31. However, alignment also carries costs and risks, particularly transition costs such as policy change, workforce training, and system redesign. Further, poorly designed alignment could result in the loss of effective sector-specific safeguards, leaving vulnerable people less protected.

What is the scope to align regulatory requirements for the use and authorisation of restrictive practices within NDIS services and across aged care and NDIS services?

32. There is scope to align regulatory requirements for the use and authorisation of restrictive practices across these sectors, as inconsistency currently creates confusion and risk for both staff and service users. For example, the prescription and administration of medication for the purpose of chemical restraint is governed by State and Territory legislation, which determines who can provide consent and under what circumstances. These legal requirements vary across jurisdictions. Aligning regulatory frameworks for consent, in relation to the authorisation of restrictive practices would reduce ambiguity and promote a more streamlined, consistent process to safeguard all stakeholders.

33. However, the use restrictive practices must remain strongly regulated, with independent oversight and a clear emphasis on prevention and minimisation. Any alignment of regulatory requirements should be accompanied by investment in safe staffing levels and workforce training in non-restrictive alternatives to ensure that consumer safety and

dignity remain paramount.

Embedding collaborative commissioning

34. The ANMF is overall supportive of the Commission's recommendation to embed collaborative commissioning, governance, and funding arrangements that enhance collaboration between Local Hospital Networks (LHNs) (also referred to as Local Health Districts (LHDs) in New South Wales), Primary Health Networks (PHNs) and Aboriginal Community Controlled Health Organisations (ACCHOs). Establishing structures that enable these organisations to plan, design, and deliver services in a coordinated manner can reduce duplication, address service gaps, and ensure care is better tailored to the needs of local communities. In particular, it is important to ensure that ACCHOs are meaningfully engaged as equal partners and provided with adequate resourcing and decision-making authority to ensure that the needs of First Nations communities are met, inequities and gaps in health outcomes are reduced, and care is delivered in a culturally safe manner.

35. Largely missing from the Interim Report are considerations of how collaborative commissioning may impact upon the health and care workforce. To enable workforce engagement, the workforce must be supported through education, training, and professional development opportunities. As a barrier to effective implementation of collaborative commissioning is the availability of a sufficiently sized and skilled workforce, sustained investment is required to attract, retain, and develop staff. One such strategy is the provision of real and sustainable increases in remuneration. In addition, pay parity for nurses and midwives between LHNs and PHNs, who often provide equivalent services but receive different levels of pay, should be addressed to strengthen recruitment and retention in these vital areas.

36. While not *explicitly* stated in the Interim Report, the ANMF is supportive of shifts away from activity-based funding towards outcome-based funding models. While activity-based funding is often used to drive 'efficiency' and 'productivity' in the health sector, this often reinforces siloes in service delivery and incentivises *quantity* over *quality* of care. A shift to

outcome-based funding will better align with the intentions expressed in the Commissions Interim Report to encourage innovation in service design, support investment in early intervention and preventive care, and enable providers to work collaboratively to improve patient outcomes rather than service throughput. The ANMF recommends that the Commission and Government consider further recommendations on the design and implementation of outcome-based funding arrangements across the health sector to enhance the quality of care delivered, reduce preventable readmissions, and ultimately enhance the productivity of the wider community.

Information Request 2.1

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

37. An effective consistent joint governance framework should formally include unions, ACCHOs, and frontline workforce representatives alongside LHNs and PHNs, ensuring decisions reflect both consumer and workforce perspectives. Shared planning processes, supported by linked datasets, jointly agreed work programs, and clear lines of accountability, are essential to create consistency and prevent duplication. Strengthened partnership requirements and data-sharing arrangements should make collaboration routine practice. Clinical leadership expertise and frontline experience must also be incorporated, while the cultural knowledge, lived experience, and community trust of ACCHOs should be positioned centrally. Genuine acknowledgement of the distinct contexts and populations that ACCHOs serve is critical to achieving a governance framework that is both consistent and responsive.

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

38. The design of an outcomes framework to support joint monitoring and reporting must explicitly track workforce wellbeing and patient outcomes and recognise the link between the two. Workforce measures such as safe staffing, retention, wellbeing, and occupational health and safety should be tracked alongside patient outcomes and experiences. Initially, this framework could focus on potentially preventable hospitalisations, with careful

attribution, risk-adjustment, and benchmarking, before expanding to cover broader integrated-care outcomes such as continuity, equity, and population health improvements. Cultural safety and inclusivity must also be embedded as core principles of monitoring and reporting, ensuring that outcomes frameworks respect and respond to the needs of Aboriginal and Torres Strait Islander peoples and draw on the expertise of ACCHOs.

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

39. Partnerships with ACCHOs must be grounded in strengths-based co-design that moves beyond consultation towards shared decision-making. This requires the explicit inclusion of ACCHOs in joint planning and governance processes, supported by investment in place-based capability-building.

Information Request 2.2

What levels of resourcing are required to: first, support enhanced joint governance requirements; and second, provide sufficient dedicated funding for collaboratively commissioned services?

40. There is a clear need for dedicated and ring-fenced resourcing for collaborative commissioning, including funding for staff backfill so clinicians can adequately and genuinely participate in planning. Pooled funding must come with strong accountability and transparency conditions around use as well as workforce protections. Incentives should not only target potentially preventable hospitalisations, but also workforce wellbeing outcomes such as reduced turnover, fewer injury claims, and improved job satisfaction as success of such a program is contingent on the workers who deliver it.

What types of funding could be pooled to support collaborative commissioning?

41. Funding to support collaborative commissioning could be drawn from pooled Commonwealth and State/Territory sources for locally tailored services, with MBS, PBS and Primary Health Network program funds more closely aligned to measurable outcomes, such as potentially preventable hospitalisations, in order to strengthen incentives for effective and efficient collaboration.

How should the funding adjustment be implemented in practice? What unintended consequences could a funding adjustment to incentivise collaborative commissioning have? Are there outcome measures beyond potentially preventable hospitalisations that should be targeted with the incentive?

42. Any adjustments to funding should be accompanied by clear, measurable, and risk-adjusted outcome benchmarks to safeguard against risks such as gaming of performance metrics, patient selection effects, and the unintended displacement of effort away from non-incentivised outcomes. Benchmarking should also incorporate measures of patient-reported outcomes and experiences (PROMs/PREMs), and other local health and integration outcomes.

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

43. Estimates of the benefits of collaborative commissioning should, beyond fiscal gains, consider improved patient health and wellbeing, reduced inequities in access and outcomes (particularly for vulnerable and Indigenous populations), enhanced care coordination across sectors, reduced workforce stress and attrition, and effective streamlining of duplicative processes.

Information Request 2.3

What else needs to be considered to implement the reform? How should the mismatched boundaries between LHNs, PHNs, ACCHOs and other organisations be addressed in implementing the different elements of the proposed reform?

44. The current mismatch between the boundaries of LHNs, PHNs, ACCHOs and other organisations can create structural barriers to collaborative commissioning. This should be addressed through the establishment of consistent governance frameworks, joint planning committees, shared outcome frameworks, and interoperable linked data systems.

45. While aligning governance boundaries is important, reform will also require strong leadership from State and Territory governments in embedding workforce standards and expectations into commissioning arrangements. Place based approaches should strengthen the capacity

of local workforces, ensure culturally safe and community led services (particularly through ACCHOs), and safeguard employment conditions to support stability and sustainability. Collaborative commissioning must not inadvertently lead to heightened pressure on workforces or fragmentation in care delivery.

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

46. To support collaborative commissioning, state and territory governments should establish interoperable linked data systems to support shared decision-making and outcome monitoring, implement funding rule adjustments to enable pooled, flexible use of resources aligned with outcome-based incentives, and embed integration requirements within Local Health Network agreements to ensure clear accountability. Governments should also build workforce capability and support collaborative commissioning by investing in training, including data literacy, and culturally safe care, and resourcing local organisations and consumer groups to participate meaningfully in system design and evaluation.

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

47. Place-based approaches across the care sector can be supported by the expansion of collaborative planning that identifies local challenges and builds on opportunities to address these through cross-sector collaboration. As above, there is a need to include the local workforce, consumer groups and communities to support place-based approaches to service change.

A national prevention framework

48. The ANMF is broadly supportive of the Commission's recommendations for increased investment in prevention programs, acknowledging their potential to deliver significant long-term benefits to both individual and population health outcomes. Preventive health measures can improve community-based outcomes, such as improved mental health and quality of life, increased life expectancy, reductions in the incidence and severity of chronic

and preventable disease, and improve health service outcomes, such as pressure on acute services, lower readmission rates and avoidable hospital presentations, and decreased demand for intensive care.

49. Complementary to prevention programs, screening programs such as those for bowel, breast, and cervical cancer, as well as newborn bloodspot and hearing screening, which target at-risk groups, also play a vital role in preventive health by detecting diseases early, often before symptoms appear. Early detection not only improves individual health outcomes and reduces mortality, but also lessens health system burden by enabling timely and less intensive treatment

50. The effectiveness of a National Prevention Investment Framework will be contingent on significant investment in the health workforce, particularly nurses and midwives. Investment in the development, implementation, operation, and evaluation of nurse- and midwifery-led models of care offers a cost-effective, evidence-based means of achieving the Commission's recommendation of reducing avoidable re-admissions. Nurse-led prevention models for chronic conditions such as diabetes, cardiovascular disease, and respiratory illness have consistently demonstrated improvements in health outcomes and reductions in hospital admissions. Further, midwifery-led continuity of care models have demonstrated improved maternal and neonatal health outcomes, reduced intervention rates, and higher levels of satisfaction with care. Embedding and scaling these models within a national prevention framework offers a sustainable pathway to improved health outcomes.

51. While prevention and screening interventions present an opportunity to reduce pressure on acute and critical care, reducing hospital readmissions, complications, and demand on intensive care units, these programs may also increase workloads in primary care, community health, and allied health settings. To ensure sustainability, investment in prevention and screening strategies must be matched with investment in the health workforce, particularly nurses, midwives, to build the required capacity. In addition, the

broader health workforce must be supported with adequate training in prevention approaches, supported by protected time for this training, to ensure that reforms aimed at enhancing productivity do not overburn staff or take away from the current quality and efficiency of care.

52. It is recommended that the establishment of a Prevention Framework Advisory Board include key stakeholders, such as workforce representatives and peak bodies, to ensure the feasibility, effectiveness, and acceptability of interventions across sectors.

Information Request 3.1

When prioritising different proposals, how should factors such as overall net benefits, net fiscal effects, cost-effectiveness, equity, ease of implementation, timescale and the value of future benefits and costs be weighted? Are there existing frameworks that do this well?

53. Rigorous and transparent prioritisation of prevention programs and health reform proposals is essential to maximise overall net benefits while balancing net fiscal effects, cost-effectiveness, equity, ease of implementation, and timing. Explicit weighting of equity impacts and workforce sustainability must be embedded in prioritisation frameworks to ensure vulnerable populations and essential workforce considerations are not overlooked. Minimum cost-effectiveness thresholds should be applied flexibly to avoid excluding initiatives that address high-need populations. Long-term prevention initiatives require protected and stable funding to prevent detrimental stop-start cycles that undermine health gains and workforce stability. To ensure accountability and transparency, an independent Prevention Framework Advisory Board should oversee program assessments and publish justifications for funding decisions. Existing national frameworks under the 2020–25 National Health Reform Agreement (NHRA), which emphasise shared accountability, joint planning, outcome-based funding, and equity-driven approaches, provide useful models for such prioritisation.

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

54. Minimum cost-effectiveness and cost-benefit thresholds should be set according to the proposals size and significance of the program for the community it serves. Importantly, analysis must consider broader community and societal benefits that are often difficult to quantify, such as reduced caregiver burden and equity gains. For larger-scale programs, a thorough cost-benefit analysis should be conducted by an independent Prevention Framework Advisory Board to ensure that investments represent value for money.

How should decision makers balance the need to assess early effectiveness of programs with the need to maintain consistent long-term funding for programs with long-term benefits?

55. Balancing the need to assess early effectiveness with maintaining consistent long-term funding requires a structured evaluation approach that uses both lead and lag indicators, alongside staged evaluations. Consistent long-term investment and multi-year funding commitments should also be established to avoid "stop-start" funding cycles that undermine program effectiveness and workforce sustainability.

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

56. A diversification strategy involves investments in a both long-term, higher-risk initiatives that offer substantial future benefits and nearer-term, lower-risk programs that deliver more immediate and certain returns. Diversification should also occur across sectors to ensure greater benefits across communities and demographics.

Information Request 3.2

How should a National Prevention Investment Framework be implemented? What is the best way to incentivise Australian, state and territory governments to invest in prevention to improve future outcomes and avoid future costs?

57. Implementation of a National Prevention Investment Framework requires establishing an independent, expert-led Prevention Framework Advisory Board (PFAB) responsible for assessing program proposals. Further funding mechanisms to support multi-jurisdiction

initiatives and co-contributions, should be established to allow for long-term fiscal effects. This should be supported through the development of an intergovernmental agreement codifying roles, responsibilities, and stable funding.

58. The Framework must recognise and support the prominent and leading role of the nursing and midwifery workforce in prevention and early intervention through co-design with frontline workers, unions, and communities, to ensure programs are practical and support both community outcomes and workforce sustainability.

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

59. To support the effective implementation of recommendations from the PFAB, changes to budget operational rules, such as enabling multi-year funding commitments that extend beyond electoral and budget cycles and enabling mechanisms that lock in stable investment for the duration of prevention programs will be required.

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

60. Alternative governance approaches should be considered to ensure the framework is both robust and flexible. The PFAB should be institutionally independent, with transparent processes for decision-making and clear criteria for assessing evidence. Governance arrangements must also support collaboration between the Commonwealth, states and territories, and other key stakeholders, including unions, professional groups, and ACCHOs.

What considerations would ensure that the framework works together with existing prevention programs funded by states and territories? How can the framework encourage governments to keep supporting existing effective prevention programs?

61. To ensure the framework works with existing state and territory prevention programs, an intergovernmental agreement that sets clear roles, responsibilities, and funding arrangements, should be established to avoid later complications. The Prevention Framework Advisory Board should assess, evaluate, and recommend which existing effective

prevention programs to keep supporting.

Conclusion

62. While the ANMF is largely supportive of the series of reforms proposed by the Productivity Commission, to increase productivity in the health and care sector, a series of reforms that are congruent with the concept of '*the right care, in the right place, at the right time*' are vital. These incudes:

a) **Presence**: Having enough of the right kind of staff both in the workforce at large and present at work (i.e., ensuring both a suitably sized and skilled workforce as well as ensuring staff absence, leave, and attrition is addressed).

b) **Placement**: Having staff where they are needed and addressing issues and challenges of geography, distance, and contextual/jurisdictional uniqueness.

c) **Timing**: Ensuring staff have sufficient time to provide services to a high-quality standard and thus matching staffing numbers with workload and demand to ensure that services are delivered when they are needed.

d) **Competency**: Ensuring staff have the education, skills, and experience to provide the right care based on the needs and preferences of patients, residents and consumers.

e) **Innovation**: Supporting staff with appropriate training, systems, management, and roles that facilitate innovative ways of delivering new and existing evidence-based care.

63. The ANMF advances the following series of reforms on delivering quality care more efficiently for the Productivity Commission and Government to consider:

1. **Address the pipeline of new workers and support ongoing skills development** through investment in high quality, accessible, and affordable education and training including secondary and tertiary education and continuing professional development

including for core skills and competencies and cutting-edge technologies and data systems.

- Establish minimum intake numbers for higher education degrees for nursing and midwifery and abolish tertiary education fees for students studying nursing, midwifery, and vocational education and training courses to become care workers (however titled) contingent on remaining within the profession/s for a set number of years.

- Establish a nationally consistent approach to transition to practice and national professional development and career framework for nurses and midwives including rolling out nationally consistent registered undergraduate student of nursing and midwifery (RUSON/M) employment programs (however named).

2. **Sustain and support the existing and future workforce with investment in workforce retention strategies** including better gender-equal pay, better working conditions and safety, flexible rostering and leave, permanent positions, workforce health, wellbeing, and support, and staff performance and career development.

    - Provide sustainable permanent funding for the Nurse and Midwife Health Program Australia to implement preventative wellbeing measures for healthcare workers to help mitigate the known psychosocial risks associated with the professions.

    - Establish and sustain incentive-based programs and workforce practices to improve recruitment and retention of nurses, midwives, and care workers including i) return to practice schemes for workers who have left the professions or industry and ii) efficient and ethical recruitment of internationally qualified nurses and midwives.

    - Legislate safe nationally consistent minimum nurse and midwife ratios in

public and private clinical settings.

3. **Support population-level health and wellbeing and reduce over-reliance on emergency services, the secondary and tertiary health sector** through investment in evidence-based public health, preventive health, and primary healthcare and workforce.

    - Provide fully funded, unlimited mental healthcare under Medicare and establish a mental health nurse program without credentialling requirements.

    - Review Federal Government health funding arrangements to ensure transparency, accountability and effective use of the health budget and to allow States and Territories to better access and utilise resources, eliminating the current disconnect between state and federally funded services such as acute care, primary care and aged care, resulting in improvements in patient flow and chronic disease management across the health sector.

    - Fund and implement a primary healthcare workforce development strategy to provide 15,000 extra education and training places for registered nurses, nurse practitioners and midwives in areas of poorer healthcare access.

4. **Enable staff to work to their full potential in effective teams and roles** by investing in addressing barriers to staff working to their full scope of practice as well as implementation and adoption of models of care that utilise staff's full scope of practice effectively with clear job roles, delegation frameworks, and supervision.

    - Provide sustainable funding for the implementation, evaluation, and scale-up of evidence-based nurse and midwife-led models of care including registered nurse prescribing and community-based primary care.

- Enable nurse practitioners, endorsed midwives, remote area nurses, and advanced practice registered nurses to directly refer patients to specialists to reduce waiting times for care. Increase the Workforce Incentive Payment Practice Stream to cover up to seven healthcare professionals, and tie payments to higher scope clinical care.
- Authorise nurse practitioners, endorsed midwives and qualified registered nurses to order diagnostic tests such as mammograms, X-rays and bone density (DEXA) scans. For endorsed midwives, this includes tests such as non-invasive prenatal testing (NIPT), pelvic ultrasound, multiple pregnancy items and iron studies.

5. **Support effective and efficient regulation that maintains safety for consumers and staff** by enhancing and streamlining health practitioner regulation through investment in reforms that improve transparency, efficiency, flexibility, and consistency for registrants and alignment of health practitioner regulation with other health sector regulation.
    - Establish a national registration and regulation system for care workers (however titled) operated by the Australian Health Practitioner Regulation Agency.
    - Introduce 'safe harbour' laws to provide a level of legislated protection to healthcare workers providing care in circumstances whereby employers have failed to address areas of risk to patient/staff safety.
    - Implement reforms necessary to reduce duplication, bureaucracy, inflexibility, and poor intersectoral collaboration in Australia's National Registration and Accreditation Scheme including a single national employment check.
6. **Develop, grow, network, and utilise research, data, and technology** through investing in new and existing high-quality digital technologies, research, evaluation,

and implementation strategies, and technological innovations for closing the research and practice gap, collecting and leveraging workforce insights, and enhancing investigation, uptake, and utilisation of data and research.

7. **Support workers by investing in paid and unpaid care work and addressing wider issues that impact productivity and efficiency** through building and sustaining access to high-quality, lifelong care services, reducing reliance on unpaid care work, and addressing access to affordable housing, social services, safe, healthy food and community spaces.