Ernst & Young Australia Operations Pty Limited
200 George Street
Sydney NSW 2000 Australia
GPO Box 2646 Sydney NSW 2001

Tel: +61 2 9248 5555
Fax: +61 2 9248 5959
ey.com/au

Shape the future with confidence

15 September 2025

Productivity Commission

Submitted online via: https://engage.pc.gov.au/page/make-a-submission

EY Australia Response to the Productivity Commission's Interim Report: Delivering quality care more efficiently

EY recognises that Australia faces a rapidly evolving economic landscape, shaped by population ageing, growing demand for care and support services, ongoing technological and digital transformation, the urgent challenges of climate change and rising geopolitical fragmentation. In such a dynamic environment, it is imperative that policy settings are regularly reviewed and refreshed to ensure Australia is positioning to maximise economic outcomes and living standards for all.

To drive meaningful gains in productivity, it is necessary to focus on amplifying those initiatives and policy levers that deliver the greatest positive impact, while reducing or retiring measures that are less effective or counterproductive. Across our four submissions to the Productivity Commission, EY has aimed to provide practical, market-based insights grounded in our experience supporting both private and public sector organisations to enhance productivity.

We consider that a clear, evidence-based approach—supported by open dialogue and collaboration between government, industry, and the broader community—will be essential to successfully navigate the challenges ahead and to deliver on the vision outlined in the Australian Government's productivity growth agenda. EY welcomes the opportunity to share further details of our analysis and recommendations as required by the Productivity Commission.

Our submissions have been prepared with the assistance of EY AI tools, for example to support research and proofreading.

David Larocca
Partner
EY Oceania CEO & Regional Managing Partner

Selina Short
Partner
EY Oceania Head of Clients & Industries

Shape the future with confidence

Key Insights

- Productivity in health and care is about efficiency and outcomes - keeping people healthier, independent and able to participate, while sustaining quality and sustainability.
- Market design and active stewardship are governments' central levers - who provides and who buys, how funding flows, and what incentives follow.
- Allocative and productive efficiency must be held in balance - resources flow to valued outcomes with cost discipline.
- The Productivity Commission's draft recommendations mainly seek to lift efficiency (with health prevention lifting allocative efficiency).
    - **Regulatory alignment**: Streamline worker screening, audit, reporting, and broader regulatory operations, freeing up $0.5-2.0 billion annually (15,000-50,000 full-time roles) - while maintaining strong protections.[1]
    - **Collaborative commissioning**: Only endures with legislated governance and clear roles, decision rights and accountabilities, giving providers confidence that shared planning and pooled funding will persist.
    - **Prevention investment**: Treat prevention as a core fiscal strategy with budget rules, pooled funds, and planned downstream service redesign and evaluation.
- Beyond these draft recommendations, five system settings could drive further gains:
    1. **Budget flexibility:** Redesign funding flows so consumers can redirect resources toward higher-value care, increasing allocative efficiency while cutting red tape.
    2. **Innovation funding:** Use structured commissioning and funding rounds to test, prove and scale better workforce and care models, shaping future supply.
    3. **Health funding reform:** Evolve purchaser-provider models with pooled regional budgets and blended payments that reward prevention, continuity, and integration – aligning incentives to value, not just activity.
    4. **Shared data and person-centred technology:** Build the information infrastructure markets need to function, freeing workforce time, improving consumer experience and strengthening stewardship.
    5. **Broader harmonisation:** Streamline market rules to reduce duplication and inequity where fragmentation and overlaps in requirements wastes resources, while preserving diversity where it drives value.

[1] 2023-24 NDIS Annual Pricing Review Report; Aged care data snapshot - 2023; Stewart Brown - Aged Care Financial Performance Survey Report; Stewart Brown - Disability Services Financial Benchmark Report 2023; EY Parthenon Strategy analysis.

Shape the future with confidence

Productivity in Care Underpins Wellbeing, Participation and Fiscal Sustainability

Australia's health and care sectors have the nation's largest and fastest growing workforces.[2] They shape productivity through care delivery and enable higher workforce participation.[3] Reliable care enables people to work, study, and live independently. When systems fail, the effects ripple through households, communities, and governments.

Growing investment in the health and care sector lifts workforce participation, particularly among women who have historically shouldered the burden of informal care.[4] By reducing the time and opportunity costs of informal care, these sectors boost labour supply and skills, capabilities, and overall productivity.

The Productivity Commission's (PC) interim report emphasises program-level productive efficiency, with allocative efficiencies in health prevention. EY builds on that foundation with a suggested system-wide approach that uses market design and strong stewardship to align incentives and scale reform. Stewardship actively shapes markets to manage risk, foster innovation and create long-term value. It must hold two aims in balance: **allocative efficiency** (directing resources to valued outcomes) and **productive efficiency** (delivering them at the lowest sustainable cost).[5]

These objectives can sometimes conflict: increasing choice may enhance value but also raise costs, while focusing on cost control can help maintain budgets but may reduce responsiveness. Policy often skews toward the easier-to-measure gains in productive efficiency, even though allocative efficiency can deliver broader, longer-term benefits.

Despite different histories, care sectors are labour-intensive, largely publicly funded and deeply interconnected. Hospital discharge depends on aged care and disability supports. Early childhood services enable parental workforce participation and support early disability identification. As people age with complex needs, aged care and disability must integrate. Providers face duplicative obligations across programs. The workforce is mobile[6] and so wage shifts or new opportunities in one sector can quickly create shortages in another. Coordinated planning, portable skills and aligned incentives are essential.

[2] National Skills Commission (2021), The Care Workforce Labour Market Study; Australian Government (2023), Intergenerational Report 2023: Australia's future to 2063; Prime Minister and Cabinet (2024), Care and Support Economy Reform at a Glance. Factsheet.

[3] Australian Bureau of Statistics Labour Force Survey (2025); EY Parthenon analysis.

[4] National Skills Commission (2021), The Care Workforce Labour Market Study.

[5] Productivity Commission (2013), On efficiency and effectiveness: some definitions, Staff Research Note, Canberra; and Gordon, J., Zhao, S. and Gretton, P. (2015), On productivity: concepts and measurement, Productivity Commission Staff Research Note, Canberra, February.

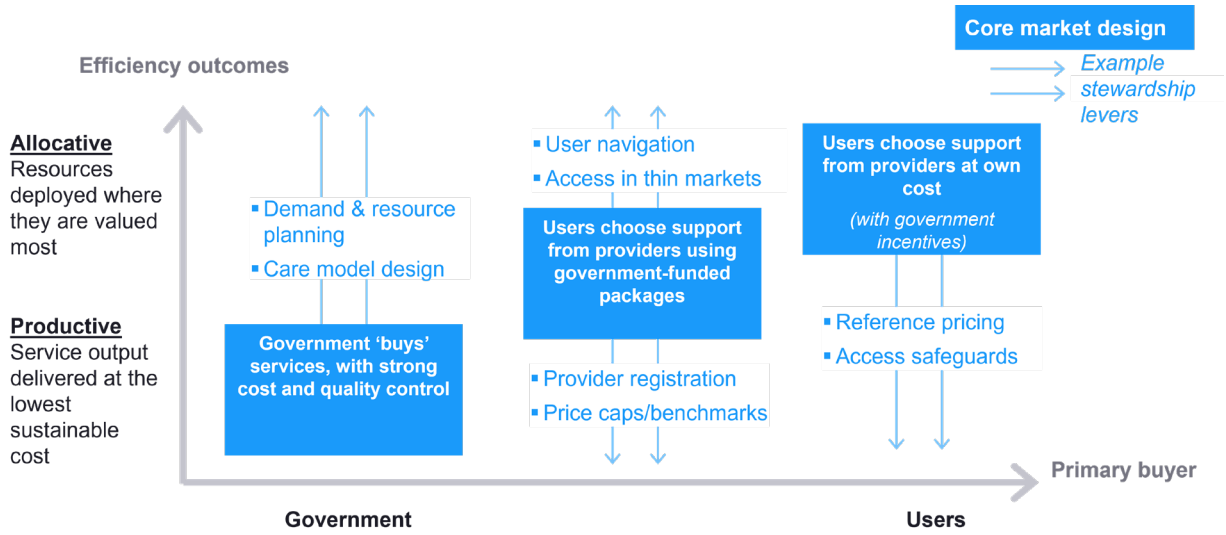
[6] Productivity Commission (2025), Delivering quality care more efficiently, Interim report.

Shape the future with confidence

Market Design and Stewardship Determine Efficiency and Outcomes

Market design determines who buys care and support, how money flows, and what incentives follow. The foundational decision is who acts as the primary buyer of care and support (see Figure 1).[7] That choice sets pricing signals, risk allocation, and accountability: shaping the balance between strong cost and quality control, value-based commissioning, and consumer choice.

Figure 1: Efficiency outcomes and stewardship levers[8]



People often make complex care decisions at moments of vulnerability with limited information. Many rely on advice from providers or intermediaries, whose incentives may not align with their preferences or needs. This reality underscores the need for well-governed, transparent markets - with clear safeguards, accessible information, and strong feedback loops - to support informed decisions and protect those who rely on care.

The buyer role and the balance between oversight and consumer choice differ by sector:

- **Public hospitals:** State governments purchase healthcare via activity-based models. Productivity focuses on doing more with finite budgets while governments carry demand risk. This brings stability and equity where care is high-cost, urgent and hard for consumers to judge.
- **Early childhood education and care and private health**: Consumers are the buyers. Transparent prices and repeated purchases can lift allocative (and sometimes productive) efficiency, but markets are fragile. Weaker providers can exit, and quality is hard to compare, so assumptions about informed choice only partly hold.
- **NDIS and parts of aged care:** Government and individuals share the purchaser role. Consumers choose supports; government sets budgets and stewards markets, intervening in thin or high-risk markets to protect equity and access.

Ownership and governance shape outcomes. Public systems offer stability and equity but tie investment to budget cycles. In aged care, disability and early childhood, mixed provision is the norm:

[7] Hallsworth, M. (2011). System stewardship: The future of policy making? Working paper for the Institute for Government, UK. April 2011; O'Flynn, J. (2019). Rethinking relationships: clarity, contingency, and capabilities. *Policy Design and Practice*, *2*(2), 115–136.

[8] ibid; EY Parthenon Strategy analysis.

smaller providers bring responsiveness and innovation, while larger organisations can scale technology and workforce systems. A balanced market can deliver both agility and efficiency; however, thin markets risk fragility, and concentrated markets risk weaker competition.

Stewardship should be matched to risk. Where risks are low, lighter-touch consumer protections are appropriate; where safety, equity, sustainability or broader social objectives are at stake, more active oversight is required. The health sector benefits from professional scaffolding through colleges and accreditation bodies. Much of the wider care economy does not, which makes clearer provider obligations, stronger workforce pathways and firmer evidence requirements essential to stabilise supply and protect consumers.

Productivity strategies should blend shared and sector-specific levers. Shared levers include digital infrastructure, workforce capability, transparent performance data, and robust compliance and fraud controls. Sector-specific levers must be tuned to each system's buyer dynamics, funding flows and risk profile. Effective stewardship balances allocative and productive efficiency by aligning incentives, clarifying decision rights, improving information flows and maintaining appropriate safeguards.

Productivity is about quality, prevention and participation

Care productivity is more than efficiency. It lifts quality and capability, better uses scarce workforce time, and prevents escalation into costly care - enabling healthier, safer and more independent lives. It also delivers wider dividends: informal carers stay in the workforce; effective disability and aged care reduce avoidable hospitalisations; early childhood investment boosts long-term skills and participation.

The PC should apply this lens across health, aged care, disability and early childhood. Key questions worth asking are: Which market designs best drive value? What population and system outcomes should guide design? How should stewardship balance choice, competition and sustainability? Above all, the focus must remain on people and their quality of life and care.

The Draft Recommendations Set a Platform, Not the Destination

The three priority reform areas and draft recommendations in the interim report target productive efficiency - reducing duplication, freeing workforce time and lowering costs - while prevention adds allocative gains. However, the deeper allocative question remains: who decides how resources flow - government or consumers?

The PC has sought feedback on the costs and benefits of regulatory alignment, the governance arrangements needed for collaborative commissioning, and how governments should structure and budget for prevention investment. Additional consideration should be given to whether these reforms will be sufficient to rebalance both productive and allocative efficiency - and to clarify the purchase role government should place across health and care systems.

1. Regulatory alignment frees workforce capacity and strengthens continuity of care

The PC highlights the case for aligning quality and safety regulation across aged care, the NDIS, veterans' care and early childhood education.[9] Alignment does not mean uniformity or reducing regulatory oversight. Sector specific standards, for example protecting children in early education and care, or clinical safety in aged care, must be preserved. The priority is to harmonise common processes and requirements under one framework, while retaining distinct safeguards where risks, service characteristics and needs differ.

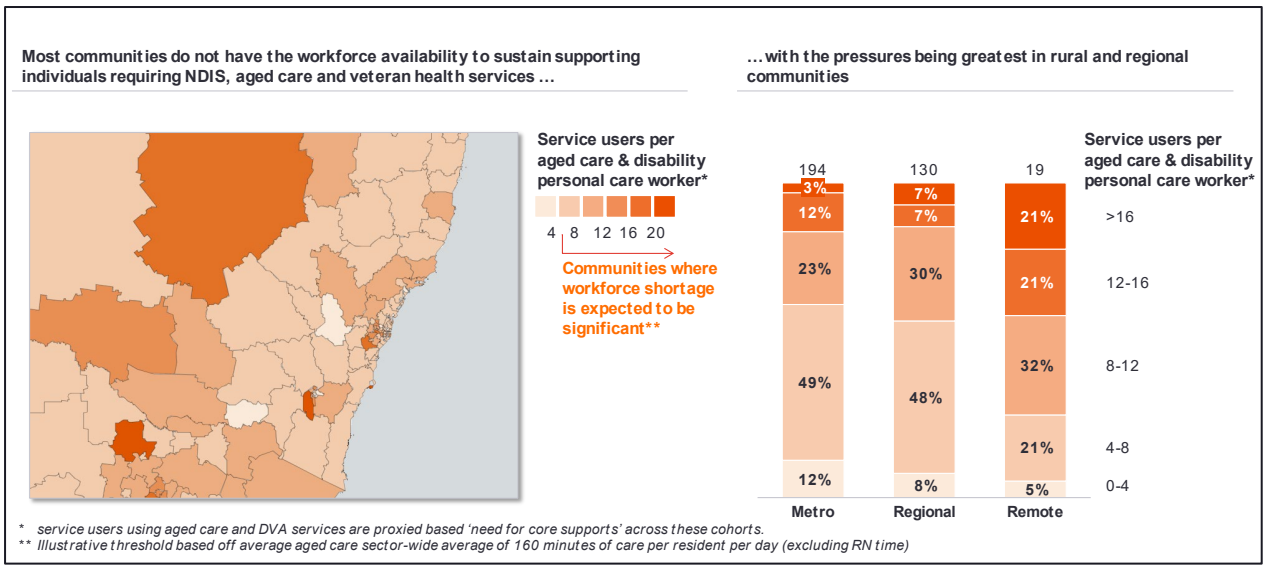
[9] Productivity Commission (2025), Delivering quality care more efficiently, Interim report, Canberra

2. Worker screening and clearances

Worker regulation and clearance schemes are fragmented and duplicative.[10] Steps toward mutual recognition exist, but a common, cross-sector clearance would materially streamline processes. For workers, the current approach means higher costs, multiple checks and delays in starting roles. For providers, it adds record-keeping, inconsistent information-sharing and onboarding delays -constraining capacity during workforce shortages. Fragmentation also creates safety gaps: without a consistent baseline, unsuitable workers can remain in the system, eroding public confidence.

A national worker screening clearance, underpinned by a common legislative framework and supported by standardised, efficient processes and shared ICT infrastructure (including continuous checking) would materially reduce duplication, delays and inconsistencies. This would in turn build public trust and unlock productivity growth while maintaining strong protections. This would also go some way to helping address workforce availability in many Australian communities, as reflected in Figure 2.[11]

Figure 2: Workforce screening – aged and disability personal care workforce availability



* service users using aged care and DVA services are proxied based 'need for core supports' across these cohorts.
** Illustrative threshold based off average aged care sector-wide average of 160 minutes of care per resident per day (excluding RN time)

The largest gains related to harmonising worker clearances come from:

- **Workforce productivity and provider efficiency**: A single clearance, with a standardised process enabled by a national register and continuous monitoring, would eliminate duplicative checks - boosting workforce productivity and provider efficiency by lowering administrative burdens, streamlining systems and accelerating staff onboarding. Indicative analysis suggests this could release $0.5-2.0 billion annually, equivalent to 15,000-50,000 full-time roles redirected to frontline care.[12]
- **Workforce mobility and retention**: Harmonised regulation would allow workers to move seamlessly across care settings, ensuring skills are deployed where they are most needed. Faster, transferable and/or mutually recognised clearances could improve workforce retention, reducing

[10] ibid

[11] Australian Bureau of Statistics Table builder (Occupation, Veteran status, Age, Support status) NDIS service users by SA2 2024 data; EY Parthenon Strategy analysis.

[12] 2023-24 NDIS Annual Pricing Review Report; Aged care data snapshot - 2023; Stewart Brown - Aged Care Financial Performance Survey Report; Stewart Brown - Disability Services Financial Benchmark Report 2023; EY Parthenon Strategy analysis.

gaps in service delivery that can delay or disrupt access to care for consumers. Anecdotal feedback from some care sector providers indicates it can take on average 28 days for a worker's clearance to be processed.[13] During this period, many workers cannot afford to 'wait' and may seek employment in other industries with an immediate start.

- **Worker experience**: Improvements made by harmonising worker screening would have a positive impact on the experience of workers in the care sector. A single worker portal where workers can manage their clearance, tied to the provider, or providers for whom they work, will enable them to keep information up to date and in turn, allow for greater visibility and oversight of worker conduct. Existing digital tools like DigitalID could support the portability of a worker's clearance and worker experience, including integrating and recognising other checks such as clinical accreditations.
- **Regulatory effectiveness**: A more aligned approach would enable better information-sharing, consistent monitoring and targeted enforcement across sectors. This would close gaps that currently allow for unsuitable workers to move between sectors. A unified registration system, supported by a national database, would improve portability across sectors, enhance information sharing and co-regulation, and likely reduce duplication in ICT infrastructure.

These reforms require collaboration across the Commonwealth, states, and territories to reconcile diverse legislation and systems. While complex, alignment is a necessary step to deliver a safer, more efficient, and more mobile care workforce. Broader opportunities to harmonise training, service models, and pricing - with even greater potential for productivity gains - are addressed later in this paper.

In response to **Draft Recommendation 1.1**, three priority reforms can drive alignment and strengthen stewardship. To succeed, each will require careful design, sequencing, and investment.

a. **Single digital portal**: A shared portal should be the foundation for more streamlined registration, audits, and compliance. The immediate priority is to integrate high-volume processes, such as worker registration and credentialing, with existing systems like myGov and the Provider Digital Pathway to avoid duplication and minimise cost. Over time, the portal could evolve into a capability and improvement platform, supporting benchmarking, surfacing real-time risk signals, and sharing quality resources. It should also provide regulators with a single, integrated view of providers and workers, enabling earlier and more targeted interventions.

b. **Single regulator:** Centralised oversight would reduce duplication for providers and enable more consistent regulation across the care economy. However, moving directly to a single regulator, risks outpacing the maturity of existing schemes and the readiness of provider markets. Some regulatory schemes are already well-established with robust data-sharing and enforcement systems, while others remain less mature or operate in markets where providers have limited capacity to engage with more complex, standardised processes.

   A more incremental approach would deliver greater and more sustainable benefits. The first step is to align standards, regulatory processes, and reporting frameworks across programs to build a consistent foundation and create clarity for providers. Over time, as data systems are modernised and provider capability strengthens, functions such as complaints handling, investigations, and capability-building can be progressively brought together. This staged approach allows for practical learning, ensures providers are not overwhelmed, and reduces the risk of disrupting care delivery. A modular legislative framework, with common rules complemented by sector-specific provisions, will also be essential to preserve the distinct safeguards required in areas such as restrictive practices.

[13] EY Parthenon Strategy analysis – anecdotal feedback received by EY from discussions with care sector providers.

Shape the future with confidence

c. **Standardised reporting:** A national reporting framework should be built around a common baseline dataset - for example, incidents and restrictive practices - that all providers must report.

   Additional requirements should scale with the risk profile of the service and provider. This approach would reduce administrative burden while providing regulators with consistent, comparable data to detect risks early and target oversight where it delivers the greatest value. Investment in interoperability and data quality will be essential to make this reporting framework actionable and trusted.

These reforms require upfront investment in ICT integration, data platforms and transitional provider support. With careful sequencing, governments can avoid short-term disruption and workforce fatigue. Experience shows that when governments fund system design, provider transition, ICT integration and monitoring, alignment reforms can generate enduring productivity and quality dividends.

3. Collaborative commissioning only sticks with legislatively backed, equitable governance

Draft Recommendation 2.1 proposes formal governance, embedded in the next National Health Reform Agreement, so Local Health Networks (LHNs), Primary Health Networks (PHNs) and Aboriginal Community Controlled Organisations (ACCOs) co-plan, pool funds and share accountability.[14] Arrangements built on goodwill are fragile and can be dominated by larger organisations. Durable models legislate roles, decision rights and accountabilities, backed by shared data and performance frameworks so decisions are transparent and progress trackable.

Victoria's Mental Health Royal Commission pointed to regional boards co-designed with service users and providers, cross-portfolio leadership at Cabinet and Secretary level, and independent statutory monitoring to secure continuity and trust.[15] While not fully implemented, the framework offers a potential template.

The NSW Health Collaborative Commissioning model[16] emphasises a shift to an inclusive, adaptive and layered governance model. Local health districts and primary health networks come together under a patient centred co-commissioning group (PCCG) to drive local governance for collaboration. PCCGs operate within a regional partnership board that balances decision-making power regardless of the relative size of funding contributions and are underpinned by a partnership agreement between the NSW and Federal Government.[17] NSW Health assumes a system manager role which provides stewardship, guidelines, access to data and enablers, and funding access. A gateway process is used to ensure intervention design is efficient, consistent with priorities and NSW Health oversees performance monitoring, evaluation and scaling. Key principles that help collaborative commissioning to endure include concepts of joint accountability, evidence-based focus, flexible purchasing and provider arrangements and promoting sustainability through resource realignment.

Globally, the UK's Integrated Care Systems[18] and New Zealand's Te Whatu Ora[19] show that collaborative commissioning "sticks" when enshrined in legislation and supported by transparent performance frameworks, independent oversight and trusted local leadership. These arrangements give providers confidence to invest in innovation and keep joint planning central to government priorities.

[14] Productivity Commission (2021). Innovations in Care for Chronic Health Conditions, Productivity Reform Case Study.
[15] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report: Summary and recommendations. February 2021.
[16] NSW Health (2024). Collaborative Commissioning website. Last update 15 March, 2024.
[17] ibid
[18] NHS England. What are integrated care systems website.
[19] Health New Zealand Te Whatu Ora. Comprehensive Primary and Community Care Teams website. Last updated 20 May, 2025.

Shape the future with confidence

4. **Prevention must be treated as core fiscal strategy**

In response to **Draft Recommendation 3.1**, prevention should be treated as a core fiscal strategy. Proposals should be required to align with prevention priorities, model avoided costs, and include plans for downstream redesign, such as closures, service shifts, or workforce transitions, to ensure that savings are realised. Funding should be provided through a multi-year, cross-portfolio pool, supported by public metrics and mechanisms for benefit-sharing.

International and Australian experience shows this is feasible. NHS England has linked community health investment to managed reductions in acute bed numbers[20], while Scandinavian systems have shifted from institutional aged care to home-based supports as prevention models matured.[21] Singapore has taken a systematic approach to addressing the social determinants of health, integrating housing, education and community services to improve outcomes and reduce hospital demand.[22]

In Australia, tobacco control, HIV responses, skin cancer campaigns and national screening programs have shown similar success. These initiatives demonstrate that prevention works when governments sustain funding, set clear outcome measures, and engage communities as active partners.[23]

Governance must be both clear and agile. Roles and accountabilities should be settled early, decision-rights streamlined, and progress against agreed outcomes measured publicly. Because prevention works over timeframes longer than typical budget or political cycles, it requires durable funding, transparent metrics, and shared accountability.

Finally, prevention is about more than reallocating spending - it empowers people. Effective prevention uses the full suite of levers: regulatory, fiscal, workforce, education, and community-led initiatives. It falters when authority is unclear, or outcomes are vague. It succeeds when metrics are transparent, communities take ownership, and incentives align.

Complementary Reforms are Needed to Accelerate and Sustain Productivity Gains

The draft recommendations set a platform, not the end-state, for a productive health and care economy.[24] We outline five practical, evidence-informed reforms to accelerate efficiency and outcomes: budget flexibility; structured innovation funding; health payment reform; shared data and person-centred tech; and broader harmonisation.

1. **Greater budget flexibility would empower care recipients, cut red tape and direct funds to where they add most value**

Across care systems, rigid budget rules limit consumers' ability to make trade-offs and exercise genuine choice. Budgets are often split into categories with little scope to move funds between them, even for low-risk items. This reduces responsiveness, creates unnecessary administrative work, and undermines person-centred planning. Done well, flexibility lifts allocative efficiency by allowing low-value items to be traded for higher-value supports within safeguards.

[20] NHS England (2025), Review of NHS performance and delivery 27 March 2025; NHS Confederation and Carnall Farrar (2023), Unlocking the power of health beyond the hospital: supporting communities to prosper – Exploring how investment in community care can improve system productivity.

[21] Luca Lorenzoni. Ageing in place – how Sweden provides and pays for universal and comprehensive care for older persons. Country reports on purchasing long-term care. World Health Organization, Centre for Health Development; Vaarrama, M. (2012). Public long-term care systems in Scandinavian countries: Recent policy shifts and future challenges. National Institute for Health and Welfare, Finland. International Conference on evidence-based Policy in Long-term care, London.

[22] Healthier SG: for a healthier Singapore and beyond. Editorial. The Lancet Regional Health – Western Pacific 2023;37:100893

[23] Francis, C. Budd, P. and Mitchell, K (2025), How can federal legislation help curb the rise of obesity in Australia? EY

[24] Productivity Commission (2025), Delivering quality care more efficiently, Interim report

Shape the future with confidence

Flexibility should be calibrated by support type and consumer circumstances, recognising different levels of risk and market maturity. This approach is less relevant in health care and residential aged care, where services are highly regulated and often subject to clinical triage and prioritisation. The greatest benefits are likely in programs where consumers interact directly with markets and where budget structures currently limit choice and responsiveness.

Practical steps can be taken now within the NDIS. Consumers and plan managers could be given more flexibility to reallocate funds for low-risk supports such as equipment, transport, or community access, supported by clearer operational guidance and system improvements. These changes would cut red tape, shorten delays in accessing critical supports, and allow consumers to make trade-offs, such as choosing lower-cost options in one area to purchase higher-quality supports in another. Safeguards would remain in place for higher-risk supports, such as restrictive practices or high-cost clinical interventions, where NDIA oversight is essential.

Recent legislative changes have tightened the scope of supports that can be funded, reflecting a stronger focus on financial sustainability.[25] Increasing flexibility within these clearer boundaries could enhance the value of consumer budgets while maintaining overall discipline. Over time, rule or legislative changes will be needed to support a more dynamic and sustainable budget framework. Options include dynamically adjusting budgets using independent, evidence-based reference prices, introducing hybrid models with co-contributions above set thresholds, and ensuring governance arrangements keep funding decisions transparent and proportionate to need. For rivalrous services, such as specialist therapy sessions under the NDIS, governments will need to decide whether to allow top-ups; for non-rivalrous services, such as standardised low-cost assistive technology, safeguards should ensure universal access at the reference price.

Preparatory work should start now. This includes analysing utilisation and cost data for therapies and basic supports to inform budget flexibility pilots, developing independent shadow reference prices for key support types, and mapping market capacity, particularly in regional and thin markets, to identify where capability support may be needed. Establishing clear metrics and evaluation frameworks early will ensure that pilot results generate robust evidence to guide future reforms.

The benefits are clear. Consumers would gain greater autonomy and faster, more consistent access to the supports that matter most. Providers would spend less time navigating administrative processes, freeing resources for frontline delivery. More dynamic and flexible budgets would also improve allocative efficiency by ensuring consumer funds flow to the supports that deliver the greatest value. International evidence shows that systems with flexible, consumer-directed funding achieve higher satisfaction, lower administrative overheads, and better outcomes.

Implementation requires investment and trust. Redesigning ICT systems, updating operational processes, and refining safeguards will involve upfront costs. These will be offset over time by reduced administrative churn and productivity gains from faster access to supports. Most importantly, a more flexible, consumer-facing system would build trust by showing that controls are proportionate to risk and that consumers are respected as capable decision-makers.

2. Structured innovation funding would trial, prove and scale better workforce and care models

Meeting future demand requires models that deliver better outcomes at lower cost, not more funding for the status quo. Innovation is critical to easing workforce and budget pressures and accelerating adoption of models that improve quality and sustainability.

[25] National Disability Insurance Agency. Summary of legislation changes – website. Last updated on 27 August 2025.

Shape the future with confidence

Three barriers constrain innovation today: limited competitive pressure (providers face demand growth without incentives to improve), activity-based pricing that rewards the status quo, and thin provider margins that restrict risk-taking.

Governments should create structured innovation rounds to guide investment priorities and manage risks. These rounds should fund both discovery (safe experimentation where solutions are not yet known) and scaling (adapting and embedding proven models from adjacent sectors or international systems).

Innovation rounds should reflect segment-specific priorities, recognising that urban primary care differs from remote aged care or complex disability supports.

Importantly, innovation funding should not rely primarily on broad outcome-based payment models. While responsive models can support exploration where problems are poorly defined, they carry risks of inequity, narrow measurement, and slow diffusion of lessons. Instead, government should prioritise structured, stewardship-led mechanisms that:

- Set clear priorities for innovation aligned to system outcomes.
- Provide targeted, time-bound funding rounds that support prototyping and real-world testing.
- Evaluate and mainstream effective models through funding, regulation, and workforce levers.
- Create shared learning infrastructure and open-source IP to spread what works across providers and sectors.

Targeted investments are already scaling innovation. In Victoria, the Virtual Emergency Department has assessed more than 250,000 people since 2020, easing emergency pressures while maintaining high satisfaction.[26] [REDACTED] At the national level, the Transition Care Program supports safe hospital discharge and delays entry to residential care.[27] The Innovative Models of Care Program is funding GP-led, multidisciplinary services in rural WA, Queensland and the NT, increasing access for underserved communities.[28]

Structured innovation funding, clear priorities, and disciplined evaluation can turn pilots into system-wide reforms that relieve workforce pressures, improve consumer experience, and strengthen sustainability.

3. Health funding reform must reward value, not volume

Current funding often rewards hospital use and episodic care. Activity-based funding and Medicare rebates ensure transparency and universal access. Blended and pooled approaches would complement these mechanisms to support prevention, continuity and integration.

The next step is to target reforms to fix the incentives that most constrain productivity. Regional pooled budgets tied to collaborative commissioning can shift resources into reablement and community supports, reducing escalation into hospital and encouraging more integrated service planning.

Hospitals need particular focus. In public hospitals, activity-based funding should keep underpinning transparency and efficiency. Funding models must reward quality and outcomes. Pricing should send

[26] Victorian Public Service Commission. Community Case Studies 2023, Revolutionising healthcare: Victoria's Virtual Emergency Department.
[27] KPMG (2019). Review of the Transition Care Programme. Final Report. Department of Health.
[28] Ibid.

clear signals for avoidable admissions, safe discharge, reablement, and effective substitution through virtual or community care.

In private hospitals, where fee-for-service and insurance settings dominate, incentives should also shift to discourage low-value interventions and encourage participation in integrated models of care. Specialists often work across public and private hospitals, so aligning funding signals is essential to support integrated, high-value care. While the mechanisms differ, the principle should be consistent: funding should not reward volume alone but support safe, high-value care that reduces unnecessary hospitalisation and improves outcomes.

These steps build on existing funding pillars and add flexibility where fragmentation drives inefficiency. To succeed, they must be underpinned by reliable outcome data and evaluation - without this, pooled and blended models risk repeating past failures. Over time, reforms can reorient incentives to improve allocative efficiency by directing resources to higher-value care and enhance productive efficiency by delivering that care at lower cost. Together, they strengthen health outcomes, participation, and long-term fiscal sustainability.

4. Shared data and people-centred technology can free workforce time, improve consumer experience and strengthen stewardship

Technology reform should reduce duplication, connect systems, and generate insights into what works. Today, data is fragmented across health, aged care, disability and veterans' care. Many systems need modernisation or replacement. Consumers retell their story, providers re-enter information, and governments lack visibility across systems. Interoperability is the foundation of productive efficiency.

Systems must be designed for people first: intuitive, respectful, and give consumers control of their information. Strong safeguards for privacy and fairness are essential to build trust.

Technology can make navigation more dynamic, guiding people through entitlements without repeated questions or duplicate requests. AI and automation can link supports, remove form-filling, and reduce complexity. For carers managing multiple systems, centralised portals and entry points can provide personalised guidance. Digital assistants can help plan transitions as needs change. These tools should complement, not replace, human judgment.

For consumers, the first wins are simple but powerful: no repeat assessments, faster payments, and a single secure digital identity across systems. Linked datasets then enable more personalised and dynamic information. They can show which supports work best or flag service gaps in real time. This shifts technology reform from "plumbing" to productivity - reducing frustration, streamlining processes and ensuring systems work seamlessly rather than in silos.

A practical path is to modernise sector-specific systems while progressively building interoperability. This includes reimagining the Provider Digital Pathway to connect across the health and care economy, leveraging existing infrastructure such as HPOS and myGov. Pathways must also link with wider government systems. Core processes like payments, identity verification and credentialing should be reused, not duplicated.

The greatest dividend comes from linked data, supported by modular systems. The main gain is higher productive efficiency - reducing duplication, enabling benchmarks, and cutting waste.

Stronger interoperability also improves integrity. Consistent, real-time data makes it harder for fraud or poor-quality practice to go undetected and reduces the need for duplicative, paperwork-heavy compliance. Instead of after-the-fact audits, governments can build proactive assurance. They can surface risks early, target oversight where it adds most value, and give consumers confidence that public funds support safe, high-quality care.

Shape the future with confidence

Integrity pressures are significant: the 2023 Independent Review of Medicare Integrity and Compliance estimated non-compliance could feasibly range from $1.5 billion - $3 billion per year,[29] and the NDIA has identified $1.4 billion in 2023-24 payment errors (including fraud and over-claiming).[30] Real-time, linked data enables proactive detection and targeted oversight, reducing paperwork-heavy compliance.

International experience reinforces these lessons. Reforms succeed when they start with interoperability and modular components, not wholesale complex ICT replacement. Early wins often come from reducing duplication in payments, credentialing, and data entry. These steps lower provider burden and build trust in reform. They also make consumer-facing improvements possible. Once systems share reliable data, governments can safely offer faster access, less form-filling, and more personalised tools. By sequencing reforms this way, countries have not only avoided costly failures but have laid the groundwork for greater consumer empowerment and more personalised care experiences.[31]

The benefits are significant. Technology and virtual models cannot replace the relationships at the core of care. They can reduce labour intensity by shifting routine tasks away from scarce workforce time. Assisted self-management and digital supports free professionals to focus on high-value interactions and reduce workforce demand. This creates space for more people to participate in other parts of the economy.

5. Broader harmonisation of workforce, services and pricing will reduce duplication, strengthen mobility and enable continuity of care

Beyond regulatory alignment, harmonising workforce systems, service models, pricing and regulatory frameworks would reduce fragmentation. The main impact is on productive efficiency - cutting duplication, lowering compliance costs and enabling greater workforce mobility. It also supports safer, more consistent care and stronger stewardship.

For providers, consolidated audits and reporting, supported by interoperable portals, would reduce inconsistent compliance demands and fragmented systems. This could free $0.2-0.8 billion annually for reinvestment into frontline service delivery.[32] But alignment should not only reduce duplication - it should also strengthen assurance.

For workers, harmonisation can open broader career pathways and reduce duplication in checks and training - but it must be applied selectively to reflect the realities of different roles and sectors:

- **Personal care workers:** Who make up a significant share of the aged care and disability workforce - portability between roles would remove barriers to mobility, support more efficient rostering, and improve continuity of care as needs change. This aligns with national VET qualification reform, where *Jobs and Skills Australia* is moving toward broader qualifications that span multiple occupations and jurisdictions, with tailored elective modules to reflect role-specific requirements.[33] Such an approach would give workers a portable core skill set, while still ensuring sector-specific depth where needed.

[29] Dr P Phillip (2023). Independent Review of Medicare Integrity and Compliance. Final Report for the Department of Health, Disability and Ageing.
[30] National Disability Insurance Agency (2023). Fraud fusion taskforce investigates $1 billion in NDIS payments in first year – website. Last updated 29 November 2023.
[31] Black Book Market Research (2025) - Global Interoperability Gaps Revealed in 2025 Healthcare Connectivity Rankings.
[32] 2023-24 NDIS Annual Pricing Review Report; Aged care data snapshot—2023; Stewart Brown - Aged Care Financial Performance Survey Report; Stewart Brown - Disability Services Financial Benchmark Report 2023
[33] Department of Employment and Workplace Relations. VET Qualification Reform – website. Last updated 30 June, 2025.

- **Nurses:** Credentialing is not the main barrier. Nurses are already registered nationally, but mobility is constrained by differences in pay, status, career progression and workplace conditions.[34] Reform in this area is less about credentialing and more about addressing these incentives and supports to make cross-sector transitions more attractive.
- **Allied health professionals:** For OTs, physiotherapists, psychologists and speech pathologists, fragmented referral pathways, inconsistent funding rules, and duplicative administrative processes remain major barriers.[35]

For consumers, targeted workforce harmonisation would mean smoother transitions between programs and greater continuity of care, without compromising the standards required in clinical or regulated settings.

On service models, embedding integrated approaches such as reablement, hospital-in-the-home, and multidisciplinary teams across settings would enable more efficient allocation of workforce and capital. These models deliver better outcomes at lower cost when supported by consistent frameworks rather than program-specific silos.

Achieving these gains also depends on pricing settings, which determine whether integration is viable and whether providers and workers respond efficiently to demand.

Establishing a consistent approach to pricing - reflecting efficient market costs while supporting fiscal sustainability - would give providers greater certainty, support fairer wages and conditions, and reduce administrative overheads. For people receiving care, harmonised prices mean fairer access to similar supports regardless of program, and greater continuity as their needs change across life stages. For governments, it offers a pathway to integrate funding models and allowing activity-based pricing where appropriate but expanding mechanisms that reward outcomes and value.

Harmonisation (raising or lowering program rates toward a standard) also improves allocative efficiency by reducing distortions, inequities, and duplication across programs. However, it can reduce productive efficiency in the short term if some services end up funded above their efficient cost. The design question is how much flexibility to allow around the harmonised reference price. Two dimensions matter:

- **Internal trade-offs:** consumers may choose higher-cost options within their budget, accepting fewer hours or units of service.
- **Top-ups:** consumers may also wish to pay privately above the reference price to access higher-quality or additional services.

In both cases, equity safeguards are critical. Providers should be required to continue offering services at the reference price so that all consumers can access safe, quality care. At the same time, allowing some flexibility through internal trade-offs or top-ups can support consumer choice, stimulate innovation, and enable a wider spread of quality and price, while preserving the baseline entitlement and protecting scheme sustainability.

Conclusion

Australia's health and care economy is a platform for national prosperity. With the right market design, governance and investment, we can deliver better outcomes, greater dignity and participation, and

[34] Australian College of Nursing (2023). National Nursing Workforce Strategy. Australian College of Nursing's response to the National Nursing Workforce Strategy consultation.
[35] Tan J et al. (2025) Trends in retention and attrition in nine regulated health professions in Australia. Australian Health Review 49, AH24268. doi:10.1071/AH24268.

fiscal sustainability. We encourage the governments to set clear timetables, fund enabling infrastructure and publish progress, while keeping strong protections. The question is not whether to act, but how quickly to align incentives, capital and capability - and resolve the purchaser question - to lock in enduring productivity gains.

Shape the future with confidence

APPENDIX

References

Australian Bureau of Statistics (2024), Table builder (Occupation, Veteran status, Age, Support status) NDIS service users by SA2 2024 data, Available at https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder

Australian Bureau of Statistics (2025), Labour Force Survey (2025), Available at https://www.abs.gov.au/statistics/labour/employment-and-unemployment/labour-force-australia/latest-release

Australian College of Nursing (2023). National Nursing Workforce Strategy. Australian College of Nursing's response to the National Nursing Workforce Strategy consultation. Available at: National nursing Workforce Strategy

Australian Institute of Health and Welfare (2023). GEN Aged Care Data: Aged care data snapshot – 2023. October 2023. Available at: Aged care data snapshot—2023 - AIHW Gen

Aged Care Quality and Safety Commission, Approved Aged Care Provider 4-stage Approval Process, Available at https://www.agedcarequality.gov.au/providers/approval-accreditation/becoming-approved-aged-care-provider/our-4-stage-approval-process

Black Book Market Research (2025) - Global Interoperability Gaps Revealed in 2025 Healthcare Connectivity Rankings. Available at: Global Interoperability Gaps Revealed in 2025 Healthcare Connectivity Rankings - Black Book | Company Newsroom of Black Book Market Research

Department of Employment and Workplace Relations. VET Qualification Reform – website. Last updated 30 June, 2025. Available at: VET Qualification Reform - Department of Employment and Workplace Relations, Australian Government

Ernst & Young (2025), How can federal legislation help curb the rise of obesity in Australia? (2025), Available at https://www.ey.com/en_au/insights/health/using-legislation-to-reduce-obesity

Hallsworth, M. (2011). System stewardship: The future of policy making? Working paper for the Institute for Government, UK. April 2011. Available at: System Stewardship | Institute for Government

Health New Zealand Te Whatu Ora. Interoperability standards website. Last updated 12 September 2024. Available at Interoperability standards – Health New Zealand | Te Whatu Ora

Health New Zealand Te Whatu Ora. Comprehensive Primary and Community Care Teams website. Last updated 20 May, 2025. Available at: Comprehensive Primary and Community Care Teams – Health New Zealand | Te Whatu Ora

KPMG (2019). Review of the Transition Care Programme. Final Report. Department of Health, March 2019. Available at: Review of the Transition Care Programme – Final Report | Australian Government Department of Health, Disability and Ageing

National Disability Insurance Agency (2023). Fraud fusion taskforce investigates $1 billion in NDIS payments in first year – website. Last updated 29 November 2023.Available at: Fraud fusion taskforce investigates $1 billion in NDIS payments in first year | NDIS

National Disability Insurance Agency (2023), Annual Pricing Review: Provider Consultation Paper (2023-2024). Available at https://www.ndis.gov.au/media/6622/download?attachment

National Disability Insurance Agency (2025). Summary of legislation changes – website. Last updated on 27 August 2025. Available at: Summary of legislation changes | NDIS

National Skills Commission (2021), The Care Workforce Labour Market Study, Australian Government (2023), Available at: https://www.jobsandskills.gov.au/sites/default/files/2023-12/Care%20Workforce%20Labour%20Market%20Study_0.pdf

NHS England. What are integrated care systems – website. Available at: https://www.england.nhs.uk/integratedcare/what-is-integrated-care/

NHS England (2023), Unlocking the power of health beyond the hospital: supporting communities to prosper. Available at: https://www.nhsconfed.org/system/files/2023-09/Unlocking-the-power-of-health-beyond-the-hospital.pdf

NSW Health (2019). Integrated care for patients with chronic conditions. NSW Government website. Current at 11 January 2019.

NSW Health (2019), Integrated care for patients with chronic conditions. Available at: https://www.health.nsw.gov.au/integratedcare/Pages/chronic-conditions.aspx

NSW Health (2020). Collaborative Commissioning. Available at: https://www.health.nsw.gov.au/Value/Pages/collaborative-commissioning.aspx

O'Flynn, J. (2019). Rethinking relationships: clarity, contingency, and capabilities. *Policy Design and Practice*, *2*(2), 115–136. https://doi.org/10.1080/25741292.2019.1621046

Dr P Phillip (2023). Independent Review of Medicare Integrity and Compliance. Final Report for the Department of Health, Disability and Ageing. Available at: https://www.health.gov.au/sites/default/files/2023-04/independent-review-of-medicare-integrity-and-compliance-final-report.pdf

Prime Minister and Cabinet (2024), Care and Support Economy Reform at a Glance. Factsheet. 28 May, 2024. Available at: Care and support economy reform at a glance | PM&C

Productivity Commission (2015), On productivity: concepts and measurement, Productivity Commission Staff Research Note (February 2015), Available at: https://www.pc.gov.au/research/supporting/concepts-measurement/concepts-and-measurement.pdf

Productivity Commission (2021). Innovations in Care for Chronic Health Conditions, Productivity Reform Case Study. Available at: https://www.pc.gov.au/research/completed/chronic-care-innovations/chronic-care-innovations.pdf

Productivity Commission (2025), Delivering quality care more efficiently, interim report (2025, Available at: https://www.pc.gov.au/inquiries/current/quality-care/interim/quality-care-interim.pdf

Stewart Brown (2023). Disability Services Financial Benchmark Report 2023. Available at: https://www.stewartbrown.com.au/images/documents/StewartBrown_-_FY23_Disability_Services_Financial_Benchmark_Report_final.pdf

Stewart Brown (2024), Aged Care Financial Performance Survey Report (2024). Available at: https://www.stewartbrown.com.au/images/documents/StewartBrown_-_Aged_Care_Financial_Performance_Survey_Report_March_2025.pdf;

Tan J et al. (2025) Trends in retention and attrition in nine regulated health professions in Australia. Australian Health Review 49, AH24268. doi:10.1071/AH24268. Available at: Trends in retention and attrition in nine regulated health professions in Australia

The Lancet Regional Health-Western Pacific (2023), Healthier SG: For a healthier Singapore and beyond (2023), Available at https://pmc.ncbi.nlm.nih.gov/articles/PMC10485661/pdf/main.pdf

The Treasury, Australian Government (2023), Intergenerational Report 2023: Australia's future to 2063. Available at: Intergenerational Report 2023

Victorian Public Sector Commission, Revolutionising healthcare: Victoria's Virtual Emergency Department. Available at: https://www.vpsc.vic.gov.au/workforce-data-state-of-the-public-sector/past-releases/2023-workforce-data-state-of-the-public-sector/community-case-studies-2023/revolutionising-healthcare-victorias-virtual-emergency-department/

WHO (2025), Ageing in place: how Sweden provides and pays for universal and comprehensive care for older persons. Country reports on purchasing long-term care, Available at: https://iris.who.int/bitstream/handle/10665/381083/B09358-eng.pdf?sequence=1