Silverchain submission

Productivity Commission: Delivering quality care more efficiently - Interim report

15 September 2025

silverchain

Acknowledgement of Country

Silverchain respectfully acknowledges the Traditional Custodians of the lands on which we work and live. We acknowledge Elders both past and present, whose ongoing effort to protect and promote Aboriginal and Torres Strait Islander cultures will leave a lasting legacy for future leaders and reconciliation within Australia. Our Innovate Reconciliation Action Plan artwork was created by artist, Charmaine Mumbulla from Mumbulla Creative. The artwork is crafted from many individual pieces and is layered to tell the Silverchain story, including our increased commitment and efforts towards healing, reconciliation, and social justice.

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Executive Summary

For 130 years Silverchain has provided high-quality, in-home health and aged care services to multiple generations of Australians. As a not-for-profit organisation, we employ more than 5,900 people, including nurses, doctors, allied health, care experts, and a dedicated research and innovation division.

We have responded to the proposals in the Productivity Commission's Interim Report in relation to how they will impact on productivity in the health and aged care sectors, with our unique perspective as community care specialists delivering both health care and aged care in the home across Australia.

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

We note that these recommendations from the Commission focus primarily on the aged care, disability and veterans care sectors in the first instance. We encourage the Commission to consider which aspects may also be applied to the health sector (primary care in the first instance) given this is also funded through the Commonwealth Government. We see significant productivity gains could be made if the health sector was also included in some of these recommendations.

We acknowledge that the Commission has addressed issues of similarity and difference across sectors in the Interim Report and we agree with the characterisation of these similarities, however we ask that the Commission exercise caution and avoid assuming that the presence of some commonalities across the care sectors means they should be aligned. It is essential to recognise and incorporate the unique nuances in care that vary based on individual needs, the group receiving the care, the specific settings in which care is provided, and the associated risks.

In considering the regulation of the care sectors, it is crucial to strike a balance between ensuring safe, quality care and avoiding the imposition of excessive auditing and compliance burdens. Over-regulation could divert valuable resources away from direct care, as funds would be needed for administration rather than being spent on actual care. The Interim Report proposes reforms to a number of care sectors that currently operate on notoriously thin margins (namely aged care, disability and early childhood care) and the cost of additional regulation may further threaten financial viability in the provider market and divert funds away from the care that is needed. It is essential to carefully weigh the benefits of stringent regulations against the potential drawbacks to ensure that the primary focus remains on delivering high-quality care to those who need it.

In general, we support proposals to align national screening clearances and regulation for workers across the care industries. While such proposals are likely to reduce administrative burden at the organisational level, they are unlikely to maximise efficiencies/productivity of care workers. For each of the activities proposed in the interim report under this topic, we have provided our insights into the potential enablers and barriers of realising the productivity benefits associated with the proposed activity.

When considering regulatory reforms, it is essential to account for the inherent risks within each sector. These risks vary based on the nature of activities, the vulnerability of care recipients, the settings of care, and the qualifications of the workers. Over-regulation could divert resources from direct care, impacting smaller organisations more significantly. Therefore, reforms should be risk-proportionate, ensuring that only necessary checks and balances are imposed to minimise risks without overburdening the sector. This balance is crucial to maintain the focus on delivering high-quality care.

In the absence of government setting regulation and standards around the use of artificial intelligence (AI) in the care sectors, organisations have already begun to develop their own governance frameworks, including Silverchain. Sector standards and guidance on this should be prioritised for the short term rather than proposing for it to be completed within three years. The Commission should also consider extending this proposal to include the health sector also. Any regulation in this space should reflect a risk proportionate response to regulation of AI.

We are concerned about the proposals that would change the regulatory arrangements for aged care (to harmonise them with other sectors) in the short to medium terms. The aged care sector has embarked on a significant reform journey to align with strengthened quality standards from November 2025 and an associated new regulatory system. We ask that the sector be given the time to embed these strengthened standards before a further change be imposed with a set of multi-sector standards.

In moving towards a multi-sector set of standards (modularised or other format), there is a real risk that the requirements become 'diluted' to allow for the most common denominator of shared similarity across sectors. This would undermine the potential for standards to be a policy lever to incentivise improved

performance if the common standards in modules were generic, and include only the minimum requirements to allow for implementation across both the sectors. Conversely, expecting sectors to rise to the strengthened Standards in aged care (for example), exposes some sectors currently operating at lower levels of requirements to undue pressure to increase their standards rapidly and possibly compromise their viability and productivity.

Embed collaborative commissioning to increase the integration of care services

We have responded to the recommendations in relation to how they will impact on productivity in the health and aged care sectors and for organisations like ours who are national and provide services through competitive grants commissioned by the Primary Health Networks in multiple states of Australia.

There are factors that we think need to be considered in implementing the proposed reform:

- The initial focus should be on improved commissioning of high prevalence and high-risk clinical issues that impact people.
- We recommend that the initial focus areas should also include supporting older people to return home with aged care support after a hospital stay rather than the current 'default' to waiting for a residential aged care place. This would mean that the primary and community-based health and aged care service systems would need to be reinforced through targeted commissioning to support this cohort of people.
- Place-based needs assessments are also needed in the aged care sector to drive market development to address needs. The aged care system does not have established population planning arrangements in the same way as the health system does. This may compromise the ability for collaborative commissioning to focus on issues that require investment and support by the aged care sector which may not have the requisite market structure to meet the ambitions of collaborative commissioning. The LHNs and PHNs are designed primarily for population planning and commissioning in the health sector and may need to extend their research, capabilities and responsibilities to aged care planning for improved collaborative commissioning.
- One key challenge for service providers like Silverchain is the inability to benefit from economies of scale with local place-based commissioning. Variation across PHNs in their capabilities and capacity for commissioning makes it difficult for larger organisations to embed a model of care that can be varied only marginally in response to local needs.
- Commissioning should aim to move towards funding for volume to funding for value with an outcomes framework that allows flexibility in how service providers can generate these outcomes.

A national framework to support government investment in prevention

We welcome the proposals to develop and embed a national framework to support government investment in prevention. This could be a key mechanism to reorient the care systems away from costly, acute sector services towards primary based prevention and early intervention. This doesn't just make compassionate sense, it will make economic sense to address issues early and prevent deterioration and other negative outcomes.

We note that this proposal is ambitious, as both cross-government and cross-sector collaboration is currently challenging. Often intra-governmental collaboration is also challenging. One possible approach is to begin with cross-government work in a single sector to assess its effectiveness before expanding to additional sectors.

We note that the proposal is that the Australian Government would establish a cross-sectoral and cross-jurisdictional National Prevention Investment Framework ('the framework') to support government investment in prevention programs. We recommend that the proposal could be strengthened by also including the aim of identifying preventative innovations that could be scaled.

We agree that the Framework needs to include a benefits realisation approach that evaluates early, short and longer term outcomes that are measurable and can be standardised across settings within each sector.

If using the Framework to select investments across portfolios, then it will be important that it does not favour only those initiatives which can demonstrate short term return on investments at the expense of important initiatives where the return on the investment cumulates over a longer time horizon.

The funding of the Framework might be scaled with an initial investment to draw from to fund programs in the first few years and then an agreed proportion of cost savings demonstrated invested by each government in subsequent years after success of the approach has been demonstrated. The more the framework helps save, the more would be invested (whether through the National Prevention Investment Fund or other mechanism).

We recommend there be an Innovation Fund attached to the Investment Fund so that service providers can be funded to demonstrate/evaluate if their innovations are achieving outcomes rather than expecting the sectors to do this before accessing government investment.

The non-government sectors have a lack of economic modelling and evaluation expertise so we recommend that if the Framework requires the consideration of the impact on productivity then there needs to be practical training, education and resources provided (such as a simple cost-effectiveness modelling template or online calculator that providers can use to generate ratios and document assumptions) to support the sectors to demonstrate improved outcomes and cost effectiveness.

About Silverchain

For 130 years Silverchain has provided high-quality, in-home health and aged care services to multiple generations of Australians. As a not-for-profit organisation, we employ more than 5,900 people, including nurses, doctors, allied health, care experts, and a dedicated research and innovation division.

Our ambition is to create a better home-care system for all Australians.

Our team provides a range of health and aged care services to more than 140,000 people each year. We specialise in home and community-based care because we believe that people should have, and prefer to have, their care in or close to their homes. We offer a comprehensive suite of health services that empower people to receive the care they need in the comfort of their own homes. Our expert teams provide a wide spectrum of health care offerings alongside our aged care services: complex and acute nursing, hospital-level treatment at home, specialist community palliative care, allied health support, and innovative digital health solutions such as remote monitoring and smart glasses virtual support. We also offer chronic and complex disease management, ensuring individuals can access high-quality health support tailored to their unique needs, within their community. We offer comprehensive aged care services including Home Care Packages (HCP), Short Term Restorative Care, and the Commonwealth Home Support Programme (CHSP) including the most complex of clinical care for these clients.

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

We will respond to the proposals in the Interim Report in relation to how they will impact on productivity in the health and aged care sectors and for organisations like ours that have dual accreditation in both health and aged care regulatory systems.

We note that these recommendations from the Commission focus primarily on the aged care, disability and veterans care sectors in the first instance. We encourage the Commission to consider which aspects may also be applied to the health sector (primary care in the first instance) given this is also funded through the Commonwealth government. We see significant productivity gains could be made if the health sector was also included in some of these recommendations.

In considering the regulation of the care sectors, it is crucial to strike a balance between ensuring safe, quality care and avoiding the imposition of excessive auditing and compliance burdens. Over-regulation could divert valuable resources away from direct care, as funds would be needed for administration rather than being spent on actual care. While larger organisations may have the capacity to absorb these additional costs, smaller organisations might struggle to do so, potentially impacting their ability to provide the same level of care. The Interim Report proposes reforms to a number of care sectors that currently operate on notoriously thin margins (namely aged care, disability and early childhood care) and the cost of additional regulation may further threaten financial viability in the provider market. It is essential to carefully weigh the benefits of stringent regulations against the potential drawbacks to ensure that the primary focus remains on delivering high-quality care to those who need it.

We acknowledge that the Commission has addressed issues of similarity and difference across sectors in the Interim Report and we agree with the characterisation of these similarities, however we ask that the Commission exercise caution and avoid assuming that the presence of some commonalities across the care sectors means they should be aligned. It is essential to recognise and incorporate the unique nuances in care that vary based on individual needs, the group receiving the care, the specific settings in which care is provided, and the associated risks. These factors should be carefully considered and integrated into any regulatory proposals to ensure they are comprehensive and effective and that we don't lose sight of the important differences across these sectors. We have provided some examples in our response to specific proposals to help identify where these differences would need to be considered in new/changed regulatory approaches.

We recommend the Commission consider the inherent risks involved in the care within each sector when determining which sectors could be aligned through regulatory reforms. There are risks inherent in the activities (e.g. wound care in the health sector), groups receiving the care (vulnerable older people at risk of falls or people with communication disability which may not be able to make complaints in the same way as others), the settings of care (in a facility or in a person's home) and the people delivering the care (the workers and their capabilities, experience, qualifications). There are of course also risks of individuals behaving in an illegal or inappropriate way. Any reforms to regulation need to consider how these risks vary across the sectors to ensure that the proposed reforms are risk-proportionate to these variations and only impose the necessary checks and balances needed to minimise these risks. An example of this may be regulation of the workers themselves with a higher 'bar' set for those providing clinical care than those providing early childhood education and care. The potential for illegal, abusive or neglectful behaviours by individuals can be minimised through regulatory reform but remediation and consequences may be better dealt with at an individual level through the justice system.

Draft recommendation 1.1: *The Australian Government should pursue greater alignment in quality and safety regulation of the care economy to improve efficiency and outcomes for care users.*

In general, we support proposals to align national screening clearances and regulation for workers across the care industries. While such proposals are likely to reduce administrative burden at the organisational level, there is limited impact in maximising efficiencies/productivity of care workers.

Adopt a unified approach to worker registration across the aged care, NDIS and veterans' care sectors, supported by a national registration system and single portal for workers required to be registered.

This proposal will streamline onboarding processes for both providers and workers in the care industries and ensure that quality safeguards are consistent across sectors. Most benefits will be gained by providers and workers who work across more than one care sector. Limited benefits may be accrued for providers and workers who specialise in one care sector (e.g. health or disability).

We encourage the Commission to prescribe that a single worker screening process be digitised and automated as much as is feasible to reduce administrative burden for providers and individual workers.

We ask the Commission to consider how workers in the health sector may also be included in this proposed reform.

It will likely lead to easier migration of workers across care sectors (e.g. aged care and disability) which may allow for surge workforces to respond to variation in need across sectors. These benefits are likely to be accrued by workers in the lowest skilled roles across the care industries and who have not invested in specialised training in a particular care industry.

The proposal may have the unintended consequence of discouraging employers from investing in sector-specific and specialised training of their workforce if there are concerns about their longevity in the sector that has invested.

Mutual recognition arrangements for health workers already registered through the National Registration and Accreditation Scheme (NRAS).

This proposal has merit; however it needs to be recognised that a significant proportion of allied health professionals are not regulated through the NRAS and are regulated through other mechanisms. There

should also be mutual recognition arrangements in place for workers registered through the self-regulating professions (e.g. speech pathologists) so that they too may benefit from the efficiency and productivity gains of this measure.

Establish mutual recognition of audits against the aged care quality standards and NDIS practice standards.

In principle this would be a welcomed initiative; however while some of the issues across these two sectors are similar (e.g. restrictive practices), there are also very specific difference in the settings, vulnerabilities and care needs of older people and people with disability that would need to be reflected in audit processes.

For example, the audit of restrictive practices in disability settings would need to focus more sharply on provider actions with people who may be unable to communicate complaints or advocate for themselves, whereas in residential aged care, restrictive practices may reflect inappropriate use of sedatives or other psychotropic medications to manage behaviours associated with dementia. In home based aged care, the provider who visits the home intermittently may have limited opportunity to monitor or influence restrictive practices put in place by the family or carers of the older person. These are important differences that would need to be reflected appropriately in any audit process looking to mutually recognise audit outcomes across these two sectors; achieving the standard in the disability sector would not guarantee that a provider is meeting the aged care sector standard in an appropriate way for their care setting and population served.

We ask the Commission to consider how the health sector may also be included in this proposed reform. We note that the Australian Commission on Quality and Safety in Health Care is currently reviewing the Health Standards with a view to a new edition. This Commission has also been tasked with developing much of the guidance for new clinical care standards in the aged care Strengthened Standards, recognising significant overlap in some aspects of the Standards and audits against them between health and aged care.

It is also important to acknowledge the specific expertise of the different regulators and precedents of them working collaboratively on areas of intersect across the sectors.

Create a single digital portal for providers to manage their registration and audits across the aged care, NDIS and veterans' care sectors.

We support improved digitisation and automation of registration, audit and other compliance requirements across sectors to reduce the administrative burden of providers servicing multiple care sectors.

Create a single (potentially modular) set of practice and quality standards across aged care and NDIS services.

The aged care sector is embarking on a significant reform journey to align with strengthened quality standards in place from November 2025 and an associated new regulatory system. We ask that the sector be given the time to embed these strengthened standards before a further change be imposed with a set of multi-sector standards.

The risk of a multi-sector set of standards (modularised or other format) is that the requirements become 'diluted' to allow for the most common denominator of shared similarity across the two sectors. This would undermine the potential for standards to be a policy lever to 'nudge' the sectors towards improved performance if the common standards in modules were generic and minimum requirements to allow for implementation across both the sectors. Conversely, expecting sectors to rise to the strengthened standards in aged care (for example), exposes some sectors currently operating at lower levels of requirements to undue pressure to increase their standards rapidly and possibly compromise their viability and productivity.

A modularised set of standards could support improved innovation and allow for providers who are developing new models of care to 'pick and mix' from standards that are appropriate to their new service context. In time this may promote innovative models of care in both sectors.

While some quality and safety issues are similar across aged care and NDIS, there are important nuances in the way these are implemented in practice in the different care sectors. It would be critical that accreditation against a modularised set of standards remained faithful to acknowledging and assessing these differences (e.g. the restrictive practices example provided previously).

Develop a cross-sectoral registration system for registered providers across the aged care, NDIS and veterans' care sectors.

We support improved digitisation and automation of registration, audit and other compliance requirements across sectors to reduce the administrative burden of providers servicing multiple care sectors.

Any registration scheme should be designed as risk proportionate with increasing requirements for care services that pose higher quality and safety risks (in line with the setting and the population group receiving care and support) with reduced obligations for those providers whose care poses lower risks to outcomes and safety of people.

Establish a common suitability assessment for providers operating across the aged care, NDIS, veterans' care and ECEC sectors.

In principle this is a positive proposal. However it is important that suitability assessments and requirements are set at a level that is achievable for different types of organisations in the different sectors and do not inadvertently skew the market towards only those that can easily meet these requirements (e.g. financial and prudential requirements set too high may discourage/discount small providers from remaining or entering the market).

Ensure a consistent approach to the regulation of artificial intelligence across the aged care, NDIS and veterans' care sectors (within three years).

In the absence of government setting regulation and standards around the use of AI in care sectors, organisations have already begun to develop their own governance frameworks, including Silverchain. We would welcome a consistent approach to the use of AI within and across sectors but this should be prioritised for the short term rather than proposing for it to be completed within three years.

The Commission should consider extending this proposal to include the health sector also.

Any regulation of the use of AI needs to consider the different risks posed to quality and safety by AI use in backend and largely administrative functions compared to the use of AI in direct care delivery. There should be a risk proportionate response to regulation of AI.

Establish a standardised quality and safety reporting framework and data repository to hold data reported against the framework, which could also be used to more consistently measure productivity and report on performance across sectors (within three years).

We welcome this initiative if:

- Administrative burden is minimal on providers needing to contribute data to the reporting framework.
- Reporting allows for providers to benchmark their performance and productivity against their own sector.
- The Framework focuses initially on process indicators with a view that in time, outcome measures may also be included[1].
- Data requirements for the framework align with standard business processes and organisations are not required to develop data specifically and only for the reporting (as is currently our experience with the aged care sector for the Quarterly Financial Reports[2]).

Explore the suitability of a single regulator across the aged care, NDIS and veterans' care sectors (within six years).

We do not support the time frame that it is proposed to be completed in. The aged care sector is undertaking once-in-a-generation reforms currently and will need to continually evolve over the next few years with the introduction of the Aged Care Act 2024 and Support at Home program from 1 November

[1] Please see the National Aged Care Quality Indicators program for an example of a reporting framework that has begun to collect and report on outcome indicators (e.g. unplanned weight loss in residents, pressure injuries) but relies on existing processes within organisations (e.g. weighing or skin checks on older people). The Quality Indicators program currently only covers the residential settings of aged care with early work underway to extend to the home based aged care service setting.

[2] A review is currently underway by the Department relating to the reporting and data burden for aged care providers – focused initially on the financial reporting requirements. This review may provide the Commission with significant insight into improvements needed for this sector to minimise administrative and reporting burden on the aged care sector – and identify what data items are of most value to standardise and report in such a framework.

2025. This legislation enacts a new regulatory system for the aged care system which will significantly impact both the regulator and every provider. Any proposal to further change this regulatory system within six years does not allow the time for evidence to be developed to determine if the new aged care regulatory system and associated investment made by the sector in place from November 2025 improves quality and safety. While the proposal itself may support harmonised systems and productivity gains – this should be considered a very long term (ten years) proposition for the aged care sector.

In collaboration with state and territory governments, explore the potential for greater alignment in the regulation of behaviour support plans and use of restrictive practices focusing on the aged care and NDIS sectors, and implement agreed actions (within six years).

We support this proposal and emphasise the need for improved guidance to care providers about behaviour support and restrictive practices. Importantly, these issues have significantly different needs, practices and requirements in the aged care sector than in the disability sector. The underlying causes of the need to manage behaviours of concern are different between the disability and aged care sectors. For example in aged care this may be dementia, cognitive decline or delirium yet in the disability sector they relate to disability needs. These differences and the way they impact practice need to be considered carefully in any moves to align the regulation of behaviour support plans and restrictive practices across sectors.

In the home based aged care sector, it is important to note that the use of restrictive practices to manage behaviours of concern are often instigated by family members not covered by government regulatory settings (commonly the use of antipsychotic medications and locked doors) and the registered provider may have limited influence over the use of these – relying on educative practices to encourage the full time carer to consider alternative ways to manage behaviours of concern. The scope of any harmonised regulatory processes would need to consider the role of the registered provider in the care setting.

Embed collaborative commissioning to increase the integration of care services

We have responded to the recommendations in relation to how they will impact on productivity in the health and aged care sectors and for organisations like ours who are national and provide services through competitive grants commissioned by the Primary Health Networks in multiple states of Australia.

Draft recommendation 2.1: *Governments should embed collaborative commissioning, with an initial focus on reducing fragmentation in health care to foster innovation, improve care outcomes and generate savings.*

There are factors that we think need to be considered in implementing the proposed reform:

- The initial focus should be on improved commissioning of high prevalence and high-risk clinical issues that impact older people. There is often a negative skew on public discussion and media coverage of the issues facing older people in accessing care (terms like ‘clogging up the system’ or ‘blocking beds’ should be avoided), but older people have the right to receive high quality care, regardless of how the current system is coping with that need. A focus on potentially preventable hospitalisations in older people would offer a national solution and could be a focus of early trials of improved commissioning approaches.
- We recommend that the initial focus areas should also include supporting older people to return home with aged care support after a hospital stay rather than the current ‘default’ to waiting for a residential aged care place. This would mean that the primary and community-based health and aged care service systems would need to be reinforced through targeted commissioning to support this cohort of people.
- Place-based needs assessments are also needed in the aged care sector to drive market development to address needs. The aged care system does not have established population planning arrangements in the same way as the health system does. This may compromise the ability for collaborative commissioning to focus on issues that require investment and support by the aged care sector which may not have the requisite market structure to meet the ambitions of collaborative commissioning. The sector suffers from significant gaps and thin markets (not just in terms of

geographic locations but in terms of specialisation such as dementia specific services or workforce availability). The LHNs and PHNs are designed primarily for population planning and commissioning in the health sector and may need to extend their research, capabilities and responsibilities to aged care planning for improved collaborative commissioning.

- The key challenge for place-based service provision is the inability to benefit from economies of scale with local place-based commissioning. For example, Silverchain currently delivers several very similar chronic and complex care management programs for a number of PHNs, all of which are slightly different and don't benefit from economics of scale. This variation across PHNs makes it difficult for larger organisations to embed a model of care that can be varied only marginally in response to local needs. A shared outcomes framework may support some consistency in commissioning structures across PHNs/LHNs to allow for economies of scale.
- Commissioning should aim to move towards funding for volume to funding for value with an outcomes framework that allows flexibility in how service providers can generate these outcomes.

A national framework to support government investment in prevention

We welcome the proposals to develop and embed a national framework to support government investment in prevention. This could be a key mechanism to reorient the care systems (in particular health and aged care) away from costly, acute sector services towards primary based prevention and early intervention. This doesn't just make compassionate sense, it will make economic sense to address issues early and prevent deterioration and other negative outcomes.

We note that this proposal is ambitious, as both cross-government and cross-sector collaboration is currently challenging. Often intra-governmental collaboration is also challenging. One possible approach is to begin with cross-government work in a single sector to assess its effectiveness before expanding to additional sectors.

Draft recommendation 3.1: *Establish a National Prevention Investment Framework to support investment in prevention, improving outcomes and slowing the escalating growth in government care expenditure*

We note that the proposal is that the Australian Government would establish a cross-sectoral and cross-jurisdictional National Prevention Investment Framework ('the framework') to support government investment in prevention programs. Its aims would be twofold: to improve outcomes for individuals, with benefits for the wider community; and to reduce demand for future acute services. We recommend that the proposal could be strengthened by also including the aim of identifying preventative innovations that could be scaled.

We agree that the Framework needs to include a benefits realisation approach that evaluates early, short and longer term outcomes that are measurable and can be standardised across settings within each sector. Longer term outcomes may not be measurable for many years, or even generations depending on the intervention, well beyond the electoral lifecycle of government who initially agrees to invest in the intervention. Interim proxy measures that indicate progress towards these very long term outcomes may be needed in the framework. We are unsure of the feasibility of indicators that can be standardised across sectors; this might be explored in subsequent iterations of the Framework.

If using the Framework to select investments across portfolios, then depending on the criteria, it may favour only those initiatives which can demonstrate short term return on investments – this may include health prevention activities that prevent hospitalisations at the expense of important initiatives where the return on the investment cumulates over a longer time horizon, particularly those involving children or older people (where increased labour force productivity will not be realised). It will be important that programs using developmental evaluation (or other contemporary approaches to evaluation) are provided sufficient opportunity to demonstrate evidence of effectiveness rather than relying on traditional academic methods of evaluation (including economic evaluation).

When using the Framework to choose investments, short-term returns may be favoured—such as health prevention efforts that reduce hospitalisations—over longer-term initiatives, especially those involving children or older adults where immediate productivity gains are less likely.

In terms of the cross-sectoral Prevention Framework Advisory Board (PFAB) we recommend the proposal be strengthened by the ability to draw on evidence from experts in each sector and the inclusion of individuals with real world experience in delivering services in the sectors.

The Framework could start with an initial investment to fund early programs, with each government later reinvesting an agreed share of proven cost savings after the approach succeeds. The more the framework helps save, the more would be invested (whether through the National Prevention Investment Fund or other mechanism).

We recommend there be an Innovation Fund attached to the Investment Fund so that service providers can be funded to demonstrate/evaluate if their innovations are achieving outcomes rather than expecting the sectors to do this before accessing government investment. The aged care sector in particular has limited funding to self-invest for these types of innovations.

The non-government sectors have a lack of economic modelling and evaluation expertise so we recommend that if the Framework requires the consideration of the impact on productivity then there needs to be practical training, education and resources provided (such as a simple cost-effectiveness modelling template or online calculator that providers can use to generate ratios and document assumptions) to support the sectors to demonstrate improved outcomes and cost effectiveness. We support the proposition that PFAB may be responsible for this type of support.

Conclusion

Thank you for the opportunity to contribute to this important discussion. We trust that our suggestions will be valuable as you continue to refine these proposals and work towards enhancing productivity and outcomes across the care sectors.

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