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Request for Further Information

What additional factors to establish a consistent joint governance framework should be considered?	The interim report has already included joint board responsibilities. Accountability for joint funding and associated outcomes should sit with the executive level or above at partner organisations. Change at this scale requires both top-down, as well as bottom-up support to be successful.
How should an outcomes framework be designed to support joint monitoring and reporting? What other factors should be considered for joint monitoring and reporting?	As project scale increases, there is a tendency to overcomplicate monitoring frameworks, which can be time-consuming and dilute the clarity of outcomes. The current evaluation of NSW Health Collaborative Commissioning by the George Institute has proven complex, involving multiple stakeholders, resulting in extended timeframes inability to gain timely insights to improve the program as it progressed. A streamlined outcomes framework aligned with the quintuple aim is recommended. In NSW, the Health Outcomes and Patient Experience platform can support collection of patient-reported outcome measures. ED and hospital avoidance must be included as key outcomes but in the context of population demographics and overall demand for healthcare services. The timeframes for monitoring should be short to ensure implementation is on track. However, timeframes for outcomes should align to the scale of the change – most likely 7-10 years.
How should LHNs and PHNs partner with ACCHOs and other organisations?	In our experience, the LHD and PHN partnership was enabled through joint board agreements and joint executive governance. Therefore, it would seem optimal for ACCHOs to be included in joint governance, particularly where there are similar numbers of providers. More broadly, it would be optimal to ensure inclusion of ACCHO's throughout the commissioning process from needs assessment through to co-design, commissioning, and further partnership on specific models of care.
What levels of resourcing are required to: first, support enhanced joint governance requirements; and second, provide sufficient dedicated funding for collaboratively commissioned services?	Funding can be a catalyst for collaboration between partner organisations to start working together. Resourcing is required for all partner organisations to facilitate the collaboration, specifically dedicated positions. Our funded Director position was located within both organisations and with responsibility to both CEs and has been a critical resource to our success. Funding for commissioned services will depend on the local context and the health needs being addressed. However, our experience highlighted the

	need for flexibility and local decision-making, especially when needing to pivot from an approved program spend.
What types of funding could be pooled to support collaborative commissioning?	There are avenues that could be considered in 'pooling' funds, especially where there are aligned needs. Consideration would need to be given to how the funding is tied, either at the State (Activity-based funding/MoH Budget Supplements) or Commonwealth through MBS or PHN flexible funds.

How should the funding adjustment be implemented in practice? What unintended consequences could a funding adjustment to incentivise collaborative commissioning have? Are there outcome measures beyond potentially preventable hospitalisations that should be targeted with the incentive?	**Funding and outcome considerations**
	• **MBS support:** Establishing a dedicated MBS item for patients enrolled in collaborative commissioning pathways would reduce reliance on PHN flexible commissioned activity.
	• **Seed funding limitations:** Initial seed funding was provided with the assumption that system inefficiencies would offset the need for ongoing investment. While existing PHN and LHD funding has supported many activities, some components—such as chronic disease screening in community pharmacies and exercise programs in local gyms—fall outside current funding structures. Without sustained funding, these initiatives are at risk of discontinuation.
	• **Impact of short-term funding:** Temporary funding discourages long-term investment and structural change. For example, the inability to secure a permanent staff specialist for outpatient services was directly linked to the four-year funding horizon.
	• **Outcome measurement challenges:** Potentially Preventable Hospitalisations (PPH) are a contested metric, particularly for chronic conditions. Elevated PPH rates in rural areas often reflect limited access to alternative care, not program ineffectiveness. For instance, in regions without a GP within 100 km, ED presentations are unavoidable.
	• **Meaningful outcome measures:** More informative indicators include:
	  • PPH and ED presentations (Triage 3–5), with contextual interpretation
	  • Rates of key interventions (eg. spirometry, sick day plans, and advance care directives)
	  • Patient-reported outcomes (eg. COPD-CAT, EQ-5D)
	  • Patient-reported access, travel distance, and out-of-pocket costs—particularly critical in rural areas where privatised specialist care is prevalent and under-measured.

What are the costs of existing collaborative commissioning programs? Is there other information that could inform estimates of the benefits of collaborative commissioning?	Cost considerations that are often overlooked in discussions: **Joint governance:** Shared governance structures incur shared overhead costs, requiring proportional contributions from each organisation to support operational functions. **Program management:** Complex initiatives necessitate dedicated resources—such as project managers, data analysts, and monitoring and

	evaluation teams—which are often underfunded despite being critical for effective implementation and outcome reporting. **Funding gaps in service transformation:** While direct clinical care is typically covered by existing funding streams, additional investment is needed to support change management, preventive care, and commissioning of services such as allied health, community pharmacy, practice nursing, and fitness providers within primary care.
What else needs to be considered to implement the reform? How should the mismatched boundaries between LHNs, PHNs, ACCHOs and other organisations be addressed in implementing the different elements of the proposed reform?	Overcoming the barriers of short-term funding cycles, our collaborative commissioning project was achievable in four years however difficult to show long-term outcomes. Developing strong governance arrangements and data sharing agreements are an important first step to managing across multiple LHDs, PHNs and ACHHOs.
Are additional supporting actions by governments needed? How can state and territory governments best support and lead change?	Established working relationships between the Commonwealth and State government health departments and clear pathways for both LHD and PHN partners to advocate to the State and Commonwealth.
How can this proposed reform be employed to further integrate and expand place-based approaches across the care sector?	**Locally led planning:** effective reform required local leadership, which can challenge traditional funding body preferences for consistency and centralised control. **Community co-design**: genuine engagement with communities is essential to ensure the relevance and sustainability of initiatives. **Locally defined outcomes:** Outcomes should be identified by local stakeholders to reflect regional priorities and needs. **Government support:** clear and consistent support for costing, business case development, and expectations for monitoring and reporting on outcomes.