6 June 2025

Via submission portal: https://engage.pc.gov.au/projects/quality-care

Catholic Health Australia Submission: Productivity Commission Inquiry, Pillar 4 — Delivering Care More Efficiently

Thank you for the opportunity to provide feedback on the Productivity Commission Inquiry, Pillar 4 — Delivering Care More Efficiently.

Catholic Health Australia (CHA) appreciates the work of the Productivity Commission in exploring policy options to rethink how Australia's care economy can deliver care more efficiently. Our submission reinforces the case for a cohesive, system-wide response—one that delivers care more efficiently and, most importantly, returns more time to care.

Our response highlights key principles to support more efficient care delivery within the proposed policy reform areas. These include:

- **Reforming funding models** to address fragmentation and remove siloes across the care economy, ensuring consistency and sustainability;
- **Fostering collaboration and trust** through more coordinated, deliberate strategies that support the implementation of integrated care models;
- **Providing tailored implementation support**, including workforce training incentives, targeted leadership development, and clear, accessible communication with consumers to keep all stakeholders meaningfully engaged throughout the process; and
- **Future-proofing the care economy** through greater investment in prevention programs that reduce long-term demand on acute and aged care services, while improving population health outcomes.

CHA remains committed to building a sustainable, person-centred, and integrated care economy. We believe policy reform must deliver high-quality and equitable care for all Australians. We welcome continued collaboration to shape funding, strengthen governance, and ensure reforms reflect clinical realities and shared system responsibilities. If you wish to discuss anything further, please contact Dr Katharine Bassett, Director of Health Policy on 0420 727 709 or at katharineb@cha.org.au.

Yours sincerely,

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Catholic Health Australia

Submission: Productivity Commission Inquiry, Pillar 4 — Delivering Care More Efficiently

June 2025

Catholic Health Australia
www.cha.org.au

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services. CHA Members provide approximately 12 per cent of all aged care facilities across Australia, in addition to around 20 per cent of home care provision.

Our members account for over 15 per cent of hospital-based healthcare in Australia and operate hospitals in each Australian state and in the Australian Capital Territory, providing about 30 per cent of private hospital care and 5 per cent of public hospital care in addition to extensive community and residential aged care.

CHA not-for-profit providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care.

Submission

Background

In 2024, the Australian Government asked the Productivity Commission to identify the highest priority reform areas under five pillars of productivity, with the goal of delivering practical and implementable policy ideas across the five pillars by the end of 2025:

1. Creating a more dynamic and resilient economy
2. Building a skilled and adaptable workforce
3. Harnessing data and digital technology
4. Delivering quality care more efficiently
5. Investing in cheaper, cleaner energy and the net zero transformation.

This submission is focused on gathering feedback on the Australian Government's proposed approach to *Pillar 4: Delivering quality care more efficiently*. With growing demand and rising costs across services like health, aged care, disability, and early childhood education, the government is seeking to improve the quality of care while easing pressure on budgets and the workforce.

The government has identified three key policy reform areas for further exploration:

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

As Australia's largest non-government network of health, community, and aged care services, Catholic Health Australia (CHA) and its members play a leading role in the care economy. With deep experience across the sector, CHA is well positioned to meaningfully contribute to the current policy reform agenda. This submission reinforces the case for a cohesive, system-wide response—one that delivers care more efficiently and, most importantly, returns more time to care.

Overall comments

CHA welcomes the identified three key policy reforms for further exploration. CHA looks forward to working with the Productivity Commission during the consultation process to ensure that the outcomes of this Inquiry fully supports high-quality and safe aged care system for all Australians irrespective of their wealth or geography, consistent with Catholic Social Justice principles.

The outcomes of this Inquiry should contribute to the broader reform agenda for a care economy that is resilient, equitable, and sustainable—one that can adapt to demographic change, emerging health challenges, and technological advancement. As such, our response highlights key principles to support more efficient care delivery within the proposed policy reform areas. These include:

- **Reforming funding models** to address fragmentation and remove siloes across the care economy, ensuring consistency and sustainability;

- **Fostering collaboration and trust** through more coordinated, deliberate strategies that support the implementation of integrated care models; and
- **Providing tailored implementation support**, including workforce training incentives, targeted leadership development, and clear, accessible communication with consumers to keep all stakeholders meaningfully engaged throughout the process.

With an ageing population, increasing rates of chronic and complex conditions, and evolving expectations around care, there is a need to reimagine how the care economy delivers high-quality, person-centred services. Prioritising support for climate and health adaptation across the care economy is crucial to address environmental determinants of health at scale. Strategic and coordinated investment in innovative models of care supported by interoperable digital infrastructure is essential to expand Australia's digital health and data-sharing capabilities. Modernised funding models, strengthened governance arrangements, and mechanisms to build shared accountability are critical to ensure any new models of care are implemented effectively.

Finally, any proposed reform should take clear steps to involve consumers, participants, and providers throughout the process. This includes implementing appropriate transitional arrangements, providing clear and accessible guidance, and embedding genuine co-design at every stage.

Contents

Response to consultation questions

Section 1: Reform of quality and safety regulation to support a more cohesive care economy

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

- ~~Not at all~~
- ~~Very little~~
- ~~Somewhat~~
- **To a great extent**

What are the reasons for your answer?

Differences in quality and safety regulation across jurisdictions and sectors significantly increase both the cost and complexity of providing and accessing care services. This is particularly evident in federated systems such as Australia's, where regulation is shared across national and state or territory governments and care is delivered across both the public and private sectors. These regulatory inconsistencies can manifest in licensing, accreditation, reporting, workforce requirements, and compliance regimes — each of which imposes administrative burdens, reduces operational efficiency, and creates barriers for both providers and patients.

For care providers, navigating differing regulatory frameworks often means maintaining duplicative systems, investing in specialised compliance staff, and tailoring operations to meet multiple sets of standards. Many CHA members operate across multiple states and are subject to different reporting requirements or clinical safety mandates depending on location. These members must reconcile the expectations of various regulators and accreditation bodies, creating inefficiencies and diverting resources away from direct patient care.

From the perspective of patients, these variations can limit access to consistent, high-quality care. Aged care providers, for instance, face a separate regulatory regime from hospitals, which can cause challenges in care transitions for older people moving between hospital and residential aged care. Patients with complex or chronic conditions often find themselves navigating a fragmented system, where differences in regulatory frameworks hinder coordination and integration of services. In mental health, for example, inconsistencies between primary care, specialist care, and community services — each regulated differently — can lead to service gaps, delays, and confusion for patients and carers.

Moreover, regulatory variation can suppress innovation and slow down the implementation of new models of care. Providers wishing to introduce digital tools, shared care arrangements, or cross-sector collaboration may find themselves hampered by inconsistent data-sharing laws, incompatible safety standards, or differing interpretations of scope-of-practice rules for health professionals.

While some variation is to be expected due to legitimate local needs, the extent of regulatory inconsistency across the care sector goes well beyond what is clinically or operationally necessary. Regulatory inconsistencies across the care economy create unintended barriers for both providers and care workers. New providers are often discouraged from operating across multiple sectors due to the high cost and complexity of compliance. Similarly, care workers may

be deterred from working across different areas of the sector, as navigating varying regulatory requirements adds to their administrative burden.

The cost implications of these regulatory differences are not just financial — they also affect workforce morale, system sustainability, and patient outcomes. Staff burnout can be exacerbated by compliance burdens and the stress of working within rigid or conflicting regulatory frameworks. System inefficiencies ultimately contribute to higher costs for funders and consumers, reducing the affordability of care.

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

- ~~Not at all~~
- ~~Very little~~
- ~~Somewhat~~
- **To a great extent**

What are the reasons for your answer?

Quality and safety regulations should be more closely aligned across care sectors and jurisdictions to reduce fragmentation, improve care outcomes, and support a more sustainable and responsive health and aged care system. While some local variation may be necessary to address specific community needs, the current level of regulatory divergence introduces avoidable inefficiencies, confusion, and inequities for both providers and consumers.

Alignment of regulations would enable greater consistency in the standard of care delivered across the country, regardless of whether a person is accessing services in hospital, primary care, aged care, or community care. Patients and families often navigate multiple care settings throughout their health journey, particularly those living with chronic, complex, or life-limiting conditions. When different parts of the system operate under incompatible safety requirements, reporting mechanisms, and service standards, care can become disjointed, and the risk of harm increases. Regulatory alignment would support smoother transitions of care and better continuity, reducing the likelihood of duplication, gaps, or delays.

For providers, harmonised regulations reduce the administrative and financial burden of managing compliance with multiple, and sometimes conflicting, standards. This is especially important for organisations operating across state lines or delivering care in both health and aged care settings. Aligned regulation allows providers to direct more resources toward patient care rather than regulatory navigation, and it makes innovation — such as integrated care models or digital health solutions — more feasible to implement at scale.

Workforce pressures also highlight the need for greater regulatory coherence. Health professionals increasingly work across settings (e.g. hospital and community, or aged care and primary care), and inconsistencies in quality and safety frameworks can create confusion about roles, responsibilities, and clinical governance. Alignment would provide clearer expectations and reduce risk for workers, while also facilitating more flexible, responsive workforce models to address care needs.

Importantly, greater alignment does not mean imposing a rigid, one-size-fits-all framework. Rather, it means developing a consistent foundation of principles, language, and standards that can be adapted to suit the care context. Shared outcome measures, interoperable reporting systems, and coordinated regulatory oversight would support a more person-centred and

integrated system of care. This could include a common definition of quality and/or key success indicators, embedded within ongoing monitoring and reporting frameworks.

Potential pilot programs

CHA would welcome the opportunity to support a series of pilots to improve safety and quality regulations:

- Cross-jurisdictional regulatory alignment pilot: This pilot would involve providers operating in multiple states trialling a harmonised set of quality and safety reporting requirements developed jointly by federal and state regulators. The aim would be to assess whether adopting a common compliance framework reduces administrative burden, improves operational efficiency, and allows providers to redirect resources toward patient care. As many CHA members deliver services across a range of care settings (i.e., public and private hospitals, aged care, community care, and social outreach), there is an opportunity for effective trialling of whether the developed set of requirements would work across multiple care settings.
- Integrated care transition pathway pilot: This initiative would implement shared clinical governance frameworks and interoperable data-sharing protocols between hospital and aged care facilities within a defined region. The pilot would test whether greater regulatory alignment in documentation, medication safety, and care planning leads to safer, more coordinated transitions and better patient outcomes.
- National consistency in scope-of-practice rules for multi-setting clinicians: This pilot would implement nationally consistent scope-of-practice rules for health professionals working across multiple care settings. For example, nurse practitioners, physiotherapists, or mental health clinicians could work under uniform scope-of-practice guidelines across hospital, aged care, and primary care settings. This pilot would explore whether clearer clinical governance and credentialing processes support workforce flexibility, reduce role ambiguity, and enhance service access. This initiative is particularly timely given the recent findings from the Commonwealth's Scope of Practice Review, which highlighted the barriers and opportunities for health practitioners to work to their full potential.[1,2]
- Digital health innovation regulatory sandbox: This pilot would enable providers to trial integrated digital health solutions — such as shared care records, AI-supported care planning, or telehealth services — within a single streamlined regulatory environment. The sandbox would help determine whether reducing regulatory fragmentation can accelerate digital adoption, improve data interoperability, and enhance clinical outcomes. An example of this innovative, iterative implementation process is captured in the case study on telehealth.
- Common quality indicators and shared outcomes framework trial: This pilot would include the development and trial of a common set of quality indicators and shared outcomes framework across care settings. Focusing on a shared patient group, such as those with chronic heart failure, this pilot would test whether consistent outcome measures improve collaboration, data consistency, and performance benchmarking across hospital, aged care, and community care sectors.
- One-stop compliance portal pilot: This pilot would create a unified digital platform where providers can submit required compliance documentation once, with information securely shared across relevant regulatory bodies. The portal would aim

[1] Unleashing the Potential of our Health workforce – Scope of Practice Review (2024), accessed at: https://www.health.gov.au/our-work/scope-of-practice-review

[2] An example of this is a recent change in reforms that have been implemented in NSW for the purposes of reducing wait times to access prescription medication and address cost barriers for families. More information is available at: https://www.nsw.gov.au/ministerial-releases/game-changing-reforms-allow-gps-to-treat-adhd-to-reduce-wait-times-and-costs

to reduce administrative workload, improve the quality and timeliness of reporting, and enhance provider satisfaction.

Case study: workforce planning

There are existing agencies within the Commonwealth Government, such as Jobs and Skills Australia (JSA), that have the expertise and capacity to lead key initiatives to drive efficiencies in workforce planning. CHA has made recommendations to the JSA Workplan for FY2025-26 on expanding the scope of JSA to cover health, disability, and aged care, given that the largest number of emerging roles have since been identified within the care economy. For example, for JSA to establish best practice guidance for data collection nationally to better understand and plan allied health activity, including supply and demand in private and public settings, and across the care economy. It is the view of CHA that an increased awareness of, and engagement with, similar agencies should be prioritised to enhance the harmonisation of quality and safety regulations across the care economy.

Case study: palliative care

Palliative care sits at the intersection of the health and aged care systems, making it a clear example of where regulatory, policy and funding model cohesion is essential. With the number of Australians aged 85 and over expected to double in the next two decades, harmonised regulation will be critical to ensuring equitable and effective palliative care delivery for this growing cohort. Currently, access to palliative care is heavily influenced by geography. People in metropolitan areas often benefit from greater choice and availability, while those in regional and rural communities face significant barriers to accessing both inpatient and home-based services. Additionally, there are discrepancies between the care an individual receives in a residential aged care home, at home, or in an inpatient setting, particularly in different jurisdictions – which can all draw on a different model of palliative care provision and therefore are aligned with different funding models.

These disparities are compounded by fragmented policy and regulatory settings across jurisdictions. While the introduction of the End-of-Life Pathway under the Support at Home program offers promise, challenges around continuity of care, accessibility, and eligibility persist. A nationally coordinated approach is needed to align health and aged care systems and relevant funding models, ensuring that all Australians—regardless of location—can access high-quality palliative care in the setting that best meets their needs, whether at home, in hospital, or in a dedicated facility.

Case study: telehealth

The telehealth rollout by Primary Health Networks (PHNs) during the COVID-19 pandemic served as an example of integrated care in a sandbox-like environment. By rapidly coordinating with local health and aged care providers, PHNs enabled continuity of care through digital platforms, particularly for regional and rural populations.[3] A key lesson from the initiative was the value of a clear, consistently applied set of principles and standards across participating organisations, which supported alignment and quality. This experience highlighted how flexible funding, local leadership, and structured implementation can drive scalable, person-centred care and inform future health system reforms.[4]

[3] Halcomb et al., (2025). Telehealth use in Australian primary healthcare during COVID-19: a cross-sectional descriptive survey. Accessed at: https://ro.uow.edu.au/articles/journal_contribution/Telehealth_use_in_Australian_primary_healthcare_during_COVID-19_a_cross-sectional_descriptive_survey/28795331?file=54076124

[4] Taylor et al., (2021). How Australian Health Care Services Adapted to Telehealth During the COVID-19 Pandemic: A Survey of Telehealth Professionals. Accessed at: https://ris.cdu.edu.au/ws/portalfiles/portal/40773277/fpubh_09_648009_2_.pdf

Section 2: Embed collaborative commissioning to increase the integration of care services

What is your experience with collaborative commissioning?

CHA members participate in a range of activities that align with the principles of collaborative commissioning, including:

- In New South Wales (NSW), collaborative commissioning is being trailed through Joint Regional Committees formed by Local Health Districts (LHDs) and Primary Health Networks (PHNs).[5] These committees identify local health priorities and commission services that address gaps in care, reduce hospital demand, or improve chronic disease management. St Vincent's Health Network Sydney encompassing St Vincent's Hospital Darlinghurst and Sacred Heart Health Service Darlinghurst, operates within the South Eastern Sydney Local Health District and maintains collaborative arrangements to ensure the provision of integrated services to communities.[6]
- The St Vincent's Health Network Sydney works with partners such as the Victor Chang Cardiac Research Institute and the Garvan Institute of Medical Research, which aligns with the principles of collaborative commissioning.[7]
- Calvary Health Care has demonstrated a commitment to integrated care models and partnerships that reflect the ethos of collaborative commissioning. These include the previous Joint Venture between Calvary and Amplar Health to expand home hospital services,[8] Calvary's Palliative and End-of-Life Care Strategy which involves collaboration with primary care providers, universities, and other stakeholders to share expertise and improve palliative care services,[9] as well as a partnership with the Murrumbidgee Local Health District and NSW Health to deliver drug and alcohol programs aimed at improving community health outcomes.[10]
- St John of God Health Care operated the Hawkesbury District Health Service under a public-private partnership with the Nepean Blue Mountains Local Health District. This collaboration aimed to deliver comprehensive healthcare services to the Hawkesbury community.[11]

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[5] New South Wales Government (2025). *Collaborative Commissioning.* Retrieved 27/05/2025 from: https://www.health.nsw.gov.au/Value/Pages/collaborative-commissioning.aspx
[6] St Vincent's Hospital Sydney (2025). *St Vincent's Health Network Sydney.* Retrieved 27/05/2025 from: https://www.svhs.org.au/about-us/st-vincents-health-network-sydney
[7] St Vincent's Hospital Sydney (2025). *Research.* Retrieved 27/05/2025 from: https://www.svhs.org.au/research-education/research
[8] Amplar Health (2020). *Calvary and Medibank selected as the provider to jointly deliver 'My Home Hospital' in South Australia.* Retrieved 27/05/2025 from: https://amplarhealth.com.au/newsroom/calvary-and-medibank-selected-as-the-provider-to-jointly-deliver-my-home-hospital-in-south-australia/
[9] Calvary Health Care (2020). *Palliative and End of Life Care (PEoLC) Strategy and Implementation Plan 2020–2024.* Retrieved 27/05/2025 from: https://www.calvarycare.org.au/about/palliative-and-end-of-life-care/peolc-strategy-and-implementation-plan-2020-2024
[10] New South Wales Government (2025). *Calvary Health Care – Drug & Alcohol.* Retrieved 27/05/2025 from: https://www.nsw.gov.au/grants-and-funding/calvary-health-care-drug-alcohol
[11] St Gohn of God Health Care (2019, 28 March). *Three years leading Hawkesbury District Health Service.* Retrieved 27/05/2025 from: https://www.sjog.org.au/news-and-media/news/2019/03/28/04/57/three-years-leading-hawkesbury-district-health-service

- Mater Health collaborates with Mater Research and Mater Education to develop new methods, practices, and techniques aimed at improving patient outcomes.[12] This integrated approach ensures that patients have access to advanced and innovative healthcare solutions. One example is Catherine's House for Mothers, Babies, ad Families, which was established in partnership with the QLD Government to deliver integrated perinatal mental health care to Queensland parents experiencing perinatal mental illness. Mater Health's focus on delivering high-quality, compassionate care throughout all stages of the healthcare journey reflects the core objectives of collaborative commissioning, which emphasises coordinated, patient-centred care across various healthcare providers and other key players in the care economy.

What are the benefits of pursuing greater collaborative commissioning?

Collaborative commissioning, where multiple stakeholders work together to design, fund, and deliver health and social care services, offers a powerful mechanism for improving outcomes, addressing fragmentation, and delivering better value for investment. As health systems around the world grapple with increasing demand, workforce shortages, and constrained budgets, collaborative commissioning emerges as a promising approach to integrate care around the needs of individuals and communities. By moving beyond siloed decision-making, this model fosters cooperation between government agencies, local health services, community organisations, private providers, and consumers.

One of the most significant benefits of collaborative commissioning is its potential to improve health outcomes through person-centred care. When funders and providers from across the care continuum work together, services can be better aligned to an individual's full range of needs — physical, mental, and social. This reduces the risk of duplication, service gaps, and inconsistent care. For example, collaborative commissioning in chronic disease management can enable better coordination between primary care, hospitals, and community services, resulting in fewer hospital admissions and better quality of life for patients.

Collaboration also enhances local responsiveness. When commissioning is informed by the insights of local providers, community organisations, and consumers, the resulting services are more likely to reflect the unique demographics, social determinants, and health priorities of a given region. This is particularly important in rural and remote areas, where mainstream models often fall short. Shared commissioning arrangements can empower local decision-makers to tailor solutions — such as integrating aged care and disability supports with primary and acute care — that would be difficult to achieve through top-down funding models alone.

Financial sustainability is another compelling benefit. Collaborative commissioning encourages shared accountability for outcomes and spending, which can help to shift investment upstream toward prevention and early intervention. Joint planning between health and social care funders — such as between public hospitals and private health insurers or between Medicare and state health systems — can reduce cost-shifting and unlock efficiencies. Pooling funds or aligning incentives can also break down barriers between funding siloes that too often impede innovation.

Collaborative commissioning could deliver significant community benefits by optimising healthcare infrastructure and medical supply procurement. In light of financial pressures in the

[12] Mater Health (2025). *Welcome to Mater Health.* Retrieved 27/05/2025 from: https://www.mater.org.au/health/about

private hospital sector, government-led joint procurement initiatives could reduce costs, support local job creation, and minimise medical waste. This would result in greater impact with Australian climate and health adaptation efforts and support the entire hospital sector as a leader in managing climate-related risks.

Importantly, collaborative commissioning provides a platform for shared learning and innovation. By bringing diverse stakeholders to the table, it creates opportunities to test new models of care, leverage data more effectively, and share best practice. It also builds trust and a common purpose among organisations that might otherwise compete or operate in isolation. This cultural shift toward partnership and collective impact is essential in addressing complex, systemic health challenges — such as inequities in Indigenous health, the rise of multimorbidity, or the transition to value-based care.

What are the barriers to collaborative commissioning, and do you have any suggestions for solutions that would lead to better collaboration in the commissioning of care services?

The vision of seamless, person-centred care often falters when confronted with the realities of entrenched structures, fragmented systems, and competing priorities. These realities often make collaborative commissioning difficult to implement at scale.

Fragmentation of funding and governance

A primary barrier is the fragmentation of funding and governance across different parts of the health and care system. Responsibility for funding and delivering services is split between multiple entities — including federal and state governments, public and private funders, and different arms of the health and social care sectors. These fragmented arrangements create incentives to shift costs rather than share them, with each player accountable for its own budget and outcomes rather than the overall wellbeing of the person or population. Without aligned funding streams, shared objectives, approaches to risk sharing, and joint accountability, genuine collaboration is difficult to sustain.

One way to address this fragmentation is the establishment of pooled or bundled funding arrangements under a joint commissioning framework, supported by shared governance structures and outcome-based accountability mechanisms. To make this work, a joint commissioning authority could be established, comprising representatives from all contributing funding authorities, service providers, and consumer groups. This body would be responsible for planning services, allocating funding based on shared priorities, undertaking quality improvement initiatives, and monitoring outcomes over the long-term. Crucially, this would need to be underpinned by formal agreements — such as intergovernmental accords or memoranda of understanding — that clarify roles, contributions, and risk-sharing arrangements. These agreements would establish a stable foundation for sustained stakeholder commitment, helping to safeguard momentum against disruptions such as staff turnover or other unforeseen changes. To drive accountability, performance should be measured against shared, person-centred outcomes — not just financial or service delivery targets for individual funders. Incentives should reward long-term improvements in health and wellbeing rather than short-term throughput.

Lack of data sharing and interoperability

Another significant barrier is the lack of data sharing and interoperability. Collaborative commissioning depends on the ability to pool and analyse data across sectors to identify

needs, track outcomes, and support continuous improvement. Yet the majority of health and care providers use incompatible IT systems, face restrictive privacy regulations, or lack the technical capacity to share data meaningfully. Without a shared view of patient journeys and system performance, it is challenging to plan services jointly or evaluate the impact of new models of care — which negatively impacts patient outcomes.

The adoption of FHIR (Fast Healthcare Interoperability Resources) as a national standard for health data exchange across the entire care — public and private, federal and state-funded— would lay the technical foundation for seamless, secure data sharing to support joint planning and commissioning. This requires a national commitment to interoperability, including the development of clear technical standards and the enforcement of compliance across software vendors and service providers. All players — whether they are general practices, public hospitals, private hospitals, aged care services, or disability providers — must be supported and funded to upgrade or align their systems to ensure they can participate in a connected care ecosystem.

Technology alone however will not be enough. Australia also needs harmonised privacy and data governance frameworks that enable the safe and lawful sharing of information for commissioning purposes. Currently, a patchwork of federal and state privacy laws, coupled with inconsistent interpretations of what is permissible, creates barriers and uncertainty. A nationally consistent approach — clarifying how data can be shared for population health planning, evaluation, and continuous improvement — would provide a strong legal and ethical foundation for collaboration. Any supporting technical frameworks should align with existing clinical governance structures to ensure stakeholder concerns are addressed and trust is maintained.

To ensure all providers can participate, there must also be investment in digital capability-building, particularly for smaller organisations, rural and remote services, and the community sector. This includes technical support, training, and access to shared tools for data analytics and performance monitoring. As part of capability-building, there also needs to be consistent efforts to report insights back to relevant stakeholders. These efforts should also be coordinated through trusted governance structures, such as regional commissioning partnerships or PHN-led collaboratives, which can oversee data access, ensure transparency through efforts to report back, and align use with agreed outcomes.

Cultural and organisational differences

Cultural and organisational differences also impede collaboration. Health, aged care, disability, and community sectors each have their own ways of working, professional languages, and measures of success. Trust and mutual understanding take time to build, particularly when organisations have previously competed for funding or operated in isolation. Power imbalances — such as between government agencies and small community-based organisations, or between funders and providers — can further undermine partnerships. If collaborative commissioning is perceived as top-down or tokenistic, it can lead to disengagement or resistance.

To address this, Australia needs to invest in structures and processes that deliberately build trust, mutual respect, and shared purpose across sectors. One practical approach is to establish regional commissioning collaboratives or alliances, co-led by representatives from diverse sectors — public and private, large and small — including consumer voices. These

collaboratives should be supported by long-term funding and governance arrangements that recognise the time and relational work required to build and sustain effective partnerships.

Crucially, these partnerships must be designed to shift power dynamics. This means moving away from top-down, government- or funder-led models towards genuinely co-designed processes where all parties — particularly community-based and First Nations organisations — have an equal say in planning and decision-making. This can be supported through shared leadership models, consensus-based governance, and transparent decision-making processes. Equally important is the flexibility to tailor partnership models to suit specific contexts — recognising that different communities, sectors, and regions may require different approaches to collaboration, depending on their needs, capacities, and cultural considerations.

Capacity-building is also key. Many community and smaller providers, especially in rural and remote areas, may need support to engage meaningfully in commissioning processes. This could include dedicated funding, training in strategic planning or data literacy, and administrative support to participate in collaborative structures. In some contexts, more participatory and tailored engagement approaches may be necessary to ensure capacity-building efforts are relevant, respectful, and genuinely empowering. Aligning these efforts with community-identified needs and the broader goals of the initiative is essential to foster meaningful and sustainable outcomes.

Importantly, the federal and state and territory governments must model collaborative behaviours themselves, aligning policy settings, objectives, and funding where possible to reduce duplication and friction. When governments, funders, and providers work together with mutual respect and aligned goals, collaborative commissioning is more likely to succeed — and more likely to be seen as genuine rather than tokenistic.

Workforce capacity and leadership

Workforce capacity and leadership are often overlooked barriers. Effective collaborative commissioning requires skilled leaders who can bridge institutional divides, facilitate consensus, and drive innovation. It also demands time and effort from frontline staff to engage in planning processes, contribute data, and adapt to new ways of working. In under-resourced systems, where staff are already stretched, this additional burden can limit the capacity for collaboration. Without dedicated resourcing, collaboration risks becoming an unfunded mandate rather than a meaningful reform.

To address this, dedicated resourcing for collaboration must be built into commissioning reforms from the outset. This means allocating funding not only for service delivery but also for the governance, coordination, and workforce participation that underpin genuine collaboration. For example, commissioning budgets should include provisions for backfilling clinical and frontline roles so staff can attend planning workshops, contribute to co-design processes, and help evaluate outcomes without compromising core service delivery.

Australia should also invest in a national leadership development strategy for collaborative commissioning, targeting emerging and existing leaders across health, aged care, disability, and social services. This could include interdisciplinary training programs focused on systems thinking, adaptive leadership, and partnership management, as well as secondment opportunities and joint leadership roles that promote cross-sector experience and relationships. As part of the training and development strategy, there should be a sustained focus on building capability in collaborative commissioning, with a strong emphasis on cultural

safety. This includes equipping staff with the skills to engage respectfully with diverse communities, co-design services with cultural competence, and embed inclusive practices that reflect the needs and values of all population groups.

PHNs, LHNs, and peak bodies all have a role to play in supporting this leadership capability, but support from governments is essential. Just as important is recognising that community organisations and Aboriginal Community Controlled Health Services often operate with lean structures and need targeted support to engage fully.

Regulatory and policy rigidity

Regulatory and policy rigidity presents another challenge in Australia's health system. Commissioning models are often constrained by rules that limit flexibility in how funding is used, what services can be commissioned, or which outcomes are measured. Programs and incentives are frequently designed in isolation, with limited regard for cross-sector alignment. In some cases, well-intentioned reforms — such as performance targets or competitive tendering — can inadvertently discourage collaboration by reinforcing silos or creating short-term pressures, resulting in limited progression towards sustainability in the care economy.[13]

To overcome this, governments must enable greater flexibility within funding and regulatory frameworks, allowing local commissioning bodies — such as PHNs, LHNs, or regional alliances — to tailor solutions to the needs of their populations. This includes removing overly prescriptive funding silos, allowing funding to follow the patient across settings, and creating mechanisms to pool resources across federal, state, and local governments. Existing reforms such as the National Health Reform Agreement provide a foundation for this kind of flexibility, but further action is needed to operationalise it at the regional level.

At the same time, there must be a rethink of how performance is measured and incentivised. Rather than focusing narrowly on activity-based targets or outputs, commissioning models should prioritise shared, person-centred outcomes that reflect the goals of integrated care — such as improved patient experience, reduced avoidable hospitalisations, or better continuity of care. Outcomes should be developed collaboratively with providers and communities, and supported by realistic timeframes and capacity-building efforts. Documenting these outcomes in a publicly available action plan can enhance accountability and build trust in collaborative commissioning as a pathway to integrated care.

Additionally, governments should reconsider the use of rigid competitive tendering processes, particularly in areas where trust and continuity are essential to effective service delivery. While competition can drive efficiency, it can also undermine collaboration by pitting providers against each other and fostering short-termism. Alternative models — such as alliance contracting, joint ventures, or outcome-based partnerships — can promote collaboration while still ensuring accountability and value for money.

Successfully establishing a collaborative commissioning model across health, aged care, and disability services could pave the way for its expansion into other areas of care service delivery – particularly with regards to the social determinants of health. While these determinants are deeply intertwined with healthcare outcomes, significant barriers between health and social service systems remain and must be acknowledged. There are various examples of CHA

[13] Risk of discontinued funding and policy may produce unintended consequences on existing efforts to improve integrated care: Lessons from PHN and Healthdirect aged care connection initiatives | Health Services Daily

member organisations attempting to address these barries. For example, St Vincent's Health Australia's work with the North Richmond Safe Injecting Room through provision of health care and mental health support, while supported in partnership with other co-located organisations that provide housing and social services supports. However, these examples of successful wraparound support and model of collaborative commissioning are treated as an exception (i.e., specific government-led project and/or competitive tendering process) instead of the norm, in which care service providers are actively enabled and empowered to collaborate through policy settings.

Demonstrating the value of collaborative commissioning

A key barrier to advancing collaborative commissioning in Australia is the lack of clear, consistent evidence and evaluation frameworks that demonstrate its value. While the rationale for integrated, person-centred care is widely accepted, robust data on the long-term impact of collaborative commissioning — particularly in terms of cost-effectiveness, health outcomes, and system sustainability — remains limited. This creates hesitation among funders and policymakers, especially in a fiscally constrained environment where there is pressure to demonstrate short-term returns on investment.

To address this, Australia needs a national evaluation framework for collaborative commissioning, developed jointly by the federal, states and territories, and key stakeholders across the care sectors. This framework should outline consistent indicators for measuring success — such as health equity, service integration, patient-reported outcomes, and system efficiency — while still allowing flexibility for local priorities and innovation. It should also support mixed-methods approaches that capture not only quantitative outcomes but also qualitative insights into how collaboration is working in practice. To embed a strong culture of monitoring and evaluation across all levels of government and sectors, these indicators should be systematically integrated into existing performance monitoring frameworks.

A key enabler of this is dedicated funding for embedded evaluation. Commissioning initiatives should include resources for independent evaluation from the outset, with funding tied not only to service delivery but also to learning and improvement, which is essential for evaluation capability-building[14]. Embedding evaluators within local collaborations — such as PHNs or LHNs — can help ensure that data collection, analysis, and feedback loops are built into ongoing service delivery as part of quality improvement initiatives.

There is also a need to build Australia's applied research capacity in this space. Partnerships between health and social care providers, academic institutions, and research bodies like the Australian Commission on Safety and Quality in Health Care or the NHMRC can help generate the high-quality, context-specific evidence needed to guide policy and practice. Programs such as MRFF could be leveraged to support long-term evaluations of integrated care, commissioning models and implementation research. To support this, a national framework for collaborative commissioning could include clear indicators and funding criteria aligned with the goal of building applied research capacity, ensuring sustained investment and impact.

Finally, a more open approach to knowledge sharing across jurisdictions is essential. Lessons from successful collaborative commissioning initiatives — such as NSW's Collaborative Commissioning program or Western Australia's regional partnership trials — should be systematically captured and widely disseminated to inform policy development and build

[14] Naccarella et al. (2007) accessed at: https://pubmed.ncbi.nlm.nih.gov/17689328/

confidence among funders and practitioners. This could include presentations at conferences, public webinars, implementation workshops, and integration into progress reporting under a national strategy to embed collaborative commissioning across care settings.

Potential pilot programs

CHA would welcome the opportunity to embed collaborative commissioning to increase the integration of care services:

- Regional integrated care hubs: This pilot would involve partnering with LHDs, PHNs, community organisations, and private health insurers to jointly commission services focused on a particular issue, such as chronic disease management or mental health. These hubs would pool funding and governance, using shared digital platforms for data exchange and patient tracking. The pilot would test outcome-based funding tied to patient-centred metrics such as reduced hospital admissions and improved quality of life.
- Joint procurement and shared infrastructure initiative: This pilot would involve collaboration with government and private funders on joint procurement of medical supplies and equipment, leveraging scale to reduce costs and waste. This could include sustainable procurement aligned with climate and healthcare resilience adaption goals. This initiative would assess cost savings, supply chain resilience, and environmental impact, demonstrating benefits beyond individual institutions to ensure sustainable community impact.
- Collaborative leadership development program: This pilot would look to engage emerging leaders from PHNs and community organisations to focus on systems thinking, partnership-building, and cultural safety. Joint projects would be identified to co-design new care pathways for complex patient groups. Success would be measured by improved collaboration and implementation of new integrated care pathways.
- Co-designed palliative and end-of-life care network: Building on Calvary Health Care's existing strategy, this pilot would include a co-commissioning network that includes primary care, aged care providers, hospitals, universities, and consumer groups to improve access and quality of palliative care. The pilot would test new funding models, shared care protocols, and outcomes-based accountability, with a strong emphasis on cultural safety and First Nations engagement.
- Public-private partnership for addiction and mental health services: This pilot would expand on existing partnerships and pilot integrated addiction and mental health programs jointly commissioned by public and private funders. The focus would be on coordinated care pathways, data sharing, and outcome-based contracting that reduces hospital demand and supports recovery in community settings.

Case study: Collaborative Commissioning in NSW

Collaborative Commissioning in NSW has shown that empowering local health teams to design care around community needs leads to more effective and sustainable healthcare. By fostering partnerships, using real-time data, and involving patients in care design—as seen in Murrumbidgee's respiratory care initiative: "Living Well, Your Way" —this model improves outcomes and coordination. Key lessons include the value of local autonomy, shared governance, flexible funding, and strong consumer engagement in delivering person-centred care.

Case study: Regional Community Partnerships Program in WA

Western Australia's Community Partnerships Program has invested $5 million since 2020 to support over 560 regional initiatives, funding grassroots projects that strengthen resilience

and deliver health, cultural, and educational outcomes. With grants of up to $50,000, the program demonstrates how dedicated funding and local governance can empower communities, promote equity, foster collaboration, and address regional challenges through flexible, targeted support.
Case study: Integrated care and commissioning initiative for people in regional, rural and remote, and First Nations peoples. The Australian Government is undertaking the Integrated Care and Commissioning initiative to respond to community identified needs and help build a sustainable care and support sector. The initiative brings together resources in health, aged care, disability, and veterans' care to better support and coordinate services in rural, remote and First Nations communities. While there are no publicly available timelines regarding this initiative, this exemplifies an integrated care pilot led at the Federal government level that could be expanded in specific contexts to develop and test innovative models of care for these communities.

Section 3: A national framework to support government investment in prevention

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

Although the advantages of investing in evidence-based prevention programs are well established, governments often hesitate to take the lead in funding these initiatives. One of the most significant barriers is the short-term political and budgetary cycle that dominates public policymaking. Evidence-based prevention programs typically require upfront investment and may only deliver measurable outcomes over a long horizon — well beyond electoral cycles or budget reporting periods. Politicians and decision-makers, often under pressure to demonstrate quick wins, may find it difficult to justify expenditure on interventions whose benefits may not materialise until years later, or which accrue outside their portfolio or jurisdiction.

In addition, limited understanding of the roles and activities undertaken across different levels of government — local, state and territory, and federal — within Australia's federated system may also be impacting investment in prevention. These differences can create inconsistencies between jurisdictions, making it difficult to establish clear accountability for achieving outcomes. Additionally, the objectives of specific prevention programs may not align neatly with the mandates of individual departmental portfolios, resulting in these programs being deprioritised in favour of more immediate or pressing concerns. As a result, investment into prevention programs may suffer from fragmented oversight and a diminished focus on realising long-term benefits.

Furthermore, there are institutional and cultural barriers within the bureaucracy that inhibit coordinated action across the care economy — which spans health, aged care, disability, early childhood, and social services. Government departments are typically structured around silos, each with its own goals, metrics, and funding envelopes. Cross-sectoral prevention programs often fall between these silos, struggling to gain traction without a clear lead agency or budget holder. Even when interdepartmental coordination mechanisms exist, they are often under-resourced or lack the authority to compel joint action. This results in a fragmentation of responsibility, reducing the likelihood of coherent investment in prevention.

A further challenge lies in the measurement and valuation of prevention outcomes. While there is strong evidence that many prevention programs are cost-effective — such as those targeting chronic disease, avoidable hospitalisations, falls prevention, or early childhood development — the benefits are often diffuse and difficult to quantify in financial terms. Unlike treatment services, where activity can be measured through service volumes and billing data, prevention outcomes may require long-term population-level tracking and sophisticated modelling to attribute impacts. Without robust and trusted tools to assess return on investment, prevention programs may appear less compelling to Treasury and budget decision-makers. Further work is needed to articulate the impact of prevention programs beyond purely financial metrics. This may involve exploring alternative assessment tools to qualify impact in meaningful terms, such as through the quintuple aim for healthcare improvement.[15]

Compounding this is the lack of political visibility and advocacy for prevention. Acute care services often have strong institutional voices — such as hospitals, unions, and professional associations — that advocate for funding based on clear demand pressures and crisis narratives. Prevention, in contrast, may be represented by less politically powerful actors, or dispersed across non-government organisations, community organisations, or primary care settings. This imbalance in political capital can skew government priorities toward reactive, rather than proactive, expenditure.

Moreover, the care economy itself is under-recognised in macroeconomic policymaking. Despite its large and growing role in employment and social wellbeing, sectors such as aged care, disability support, and mental health have historically been marginal to productivity and economic reform agendas. This blind spot contributes to underinvestment in programs that could deliver both social and fiscal dividends through better outcomes and reduced demand for high-cost services. For instance, prevention initiatives that reduce carer burnout, delay residential aged care admissions, or support people with disability to maintain independence are often overlooked despite their substantial potential value.

Finally, data and evaluation infrastructure across the care economy remains underdeveloped. Many prevention programs lack the continuous data collection and independent evaluation needed to build the case for scaling or replication. Pilot programs, often reliant on time-limited grants, may not be rigorously assessed or linked into national systems for knowledge translation. This undermines the cumulative evidence base and reduces policymakers' confidence in the reliability or generalisability of outcomes — particularly when outcomes are context-specific and difficult to adapt across settings.

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

As mission-based organisations, CHA members operate a range of prevention programs to promote social and community benefits, especially for vulnerable populations. Some examples of these programs include:

- Catholic Healthcare's Stepping On program,[16] which is an evidence-based, community-based program aimed at reducing the risk of falls among older adults. This program has

[15] Accessed at: https://www.ihi.org/resources/publications/quintuple-aim-health-care-improvement-new-imperative-advance-health-equity
[16] Catholic Healthcare's Stepping On: falls prevention program, accessed at: Stepping On Falls Prevention Program | Catholic Healthcare

been designed for participants aged 65+ who live at home and have either experienced a fall and/or fears of falling. The program combines education from health professionals with peer support in group settings to improve confidence and strength of participants in fall prevention.

- Mater Hospital which facilitates a range of antenatal education, breastfeeding support, and early parenting programs[17] that promote healthy starts to life. These are preventive in nature, aiming to reduce complications and improve long-term outcomes for mothers and babies.
- St John of God Healthcare delivers the South West Community Alcohol and Drug Service (SWCADS),[18] offering locally tailored programs that address the impact of alcohol and drug use on individuals and families. The service focuses on prevention through counselling, education, and training, helping participants better understand and manage harmful substance use.

CHA members also manage 27 community mental health outreach (CMH) programs across Australia. All CMH programs work with at least one or more priority population group, including people experiencing alcohol and other drug dependence, people identifying as Aboriginal and Torres Strait Islander, and people in low socioeconomic groups.

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

Governments considering investment in prevention initiatives should leverage the expertise of established evaluation bodies, such as the Australian Centre for Evaluation (ACE). Partnering with such agencies to conduct robust impact assessments can provide critical insights to inform decisions about initiating or scaling effective prevention programs. To ensure consistency and rigour, governments should integrate existing evaluation frameworks and best-practice tools — such as the Evaluation Toolkit[19] — into their ongoing quality assurance processes. The findings from these assessments should then be synthesised into concise policy briefs for relevant stakeholders, supporting evidence-informed investment in prevention activities.

Governments should prioritise strategic partnerships and actively pursue collaborative commissioning as a core component of investment decisions into preventative efforts. Doing so will require addressing previously identified barriers and fostering joint funding arrangements that embed collaborative commissioning across the care economy. This approach should be guided by a clear, government-led strategy to ensure sustained and coordinated implementation of prevention activities.

To drive increased investment in prevention, governments should develop a clear and actionable plan that supports strategic, evidence-informed decision-making. This plan should incorporate measurable progress indicators and align with existing national frameworks and

[17] Mater Mothers (2025). *Mater Hospital's Parenting Support Centre*. Retrieved 27/05/2025 from: https://matermothers.org.au/antenatal-and-pregnancy-services/parenting-support-centre
[18] St John of God Health Care (2025). *South West Community Alcohol and Drug Service.* Retrieved 27/05/2025 from: https://www.sjog.org.au/our-services/community-and-youth-services/south-west-community-alcohol-and-drug-service
[19] Australian Government, The Treasury (2025). *Commonwealth Evaluation Toolkit*. Retrieved 27/05/2025 from: https://evaluation.treasury.gov.au/toolkit/commonwealth-evaluation-toolkit

policies, such as the *National Preventive Health Strategy 2021–2030.*[20] Regular monitoring and transparent reporting against these indicators will help foster accountability and promote coordinated investment efforts across all levels of government. Specific components of the action plan could be tracked against the following dimensions[21]:

- **Organisational environment:** This dimension focuses on the broader context and conditions in which the investment framework is communicated or operationalised in government. It reflects the internal culture, leadership, and structures that shape how strategies are communicated across government. It includes actions to engage staff—such as training, clear messaging, and incentives—to build understanding and support for implementation of initiatives like a whole-of-government investment strategy. It also involves senior leadership actively endorsing and modelling adoption of the investment strategy, ensuring alignment across all aspects of government.
- **Workforce capacity:** This dimension focuses on the people responsible for implementing the investment framework—their skills, knowledge, and engagement. It reflects whether staff are equipped and supported to deliver change, particularly in investment planning and delivery. Key enablers include training, mentoring, and collaboration, with leadership playing a vital role in fostering continuous learning and aligning workforce capabilities with strategic goals.
- **Resource:** This dimension refers to the availability and effective use of key enablers—such as funding, time, tools, and evidence—needed to build and sustain capability. It reflects whether government has access to the practical supports required to implement and embed initiatives like an investment framework. Adequate resourcing ensures staff have the time to engage, the tools to work efficiently, and the evidence base to make informed decisions.
- **Learning environment:** This dimension focuses on the organisational conditions that support continuous learning and improvement. It includes the presence of trust, a culture of inquiry, and openness to feedback and reflection. A strong learning environment encourages staff to share ideas, question assumptions, and learn from successes and failures. These conditions are essential for building adaptive capability and embedding new practices, such as investment planning and strategic decision-making.

Potential pilot programs

CHA would welcome the opportunity to support government investment in prevention:

- Long-term impact and return on investment demonstration pilot: This pilot would be a multi-year prevention program (e.g. falls prevention, chronic disease self-management) with embedded, rigorous longitudinal evaluation to track health, social, and economic outcomes over time using a broad set of metrics (e.g. equity, experience, and workforce sustainability) consistent with the indicators developed as part of the national framework. The pilot would look to address barriers with data-sharing and knowledge translation across both government and non-government groups. Results would be translated into accessible policy briefs targeting The Treasury to build confidence in long-term return-on-investment.

[20] Australian Government, Department of Health, Disability and Ageing (2021). *National Preventative Health Strategy 2021–2030.* Retrieved 27/05/2025 from: https://www.health.gov.au/resources/publications/national-preventive-health-strategy-2021-2030?language=en

[21] Naccarella et al. (2007).

- Cross-sectional collaborative commissioning hub for prevention: This pilot would involve local PHNs, aged care providers, state and territory health departments, and community care providers to jointly commission prevention programs across health, aged care, and social services sectors. The pilot would test new governance models that break down siloed funding and accountability by sharing pooled budgets, risks, and benefits. Clear governance and shared key performance indicators would enable consistent cross-jurisdictional oversight, making prevention a coordinated priority beyond departmental silos.
- Prevention data and digital infrastructure pilot: This pilot would be an integrated data platform that links prevention programs with broader care economy datasets (including primary care, community services, and government datasets that currently collect and report on key indicators of health system performance). This pilot would address data and evaluation infrastructure gaps by enabling continuous outcome measurement, real-time monitoring, and predictive modelling. It would trial advanced evaluation frameworks to better quantify diffuse prevention benefits beyond direct financial metrics, supporting better-informed government investment decisions. This should also leverage existing frameworks on health and wellbeing policy agendas, such as *Measuring What Matters*.[22]

Case study: Hospital in the Home

Despite the enormous opportunity for improved productivity and health outcomes, out of hospital (OOH) care and hospital in the home (HITH) have been described as the 'missing sector' in Australia's care economy. Private health insurers have estimated that expanded HITH could save the private health system $1.3 billion per year.[23] HITH is also a preventative intervention, known to be more efficient and effective when compared to traditional inpatient care, with evidence demonstrating lower readmission rates, shorter lengths of stay, reduced mortality, and increased patient satisfaction.[24] CHA believes that there is a need for a national framework to coordinate and encourage investment into designing incentives to fund large-scale preventative interventions like HITH.[25]

[22] *Measuring What Matters* refers to a framework with five wellbeing themes, including a healthy society, sense of security, sustainable use of resources, demonstrates a cohesive culture, and is prosperous. Accessed at: https://treasury.gov.au/policy-topics/measuring-what-matters

[23] There's no place like home: Reforming out-of-hospital care (2023) Private Healthcare Australia. Available at: https://www.privatehealthcareaustralia.org.au/wp-content/uploads/20230523_PHA-Report_Reforming-out-of-hospital-care.pdf

[24] Out of hospital care in Australia (2021) Catholic Health Australia. Available at: https://www.cha.org.au/wp-content/uploads/2021/03/6- CHA-Report-J170720.pdf; and Cross, J., et al (2020). 'Supporting choice: an innovative model of integrated palliative care funded by a private health insurer.' Internal Medicine Journal, 50(8), pp.931-937.

[25] https://cha.org.au/hospital-in-the-home-care-where-patients-want-it/