BCA
Business Council of Australia

Supporting a Healthy and Productive Nation

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BCA

Business Council of Australia

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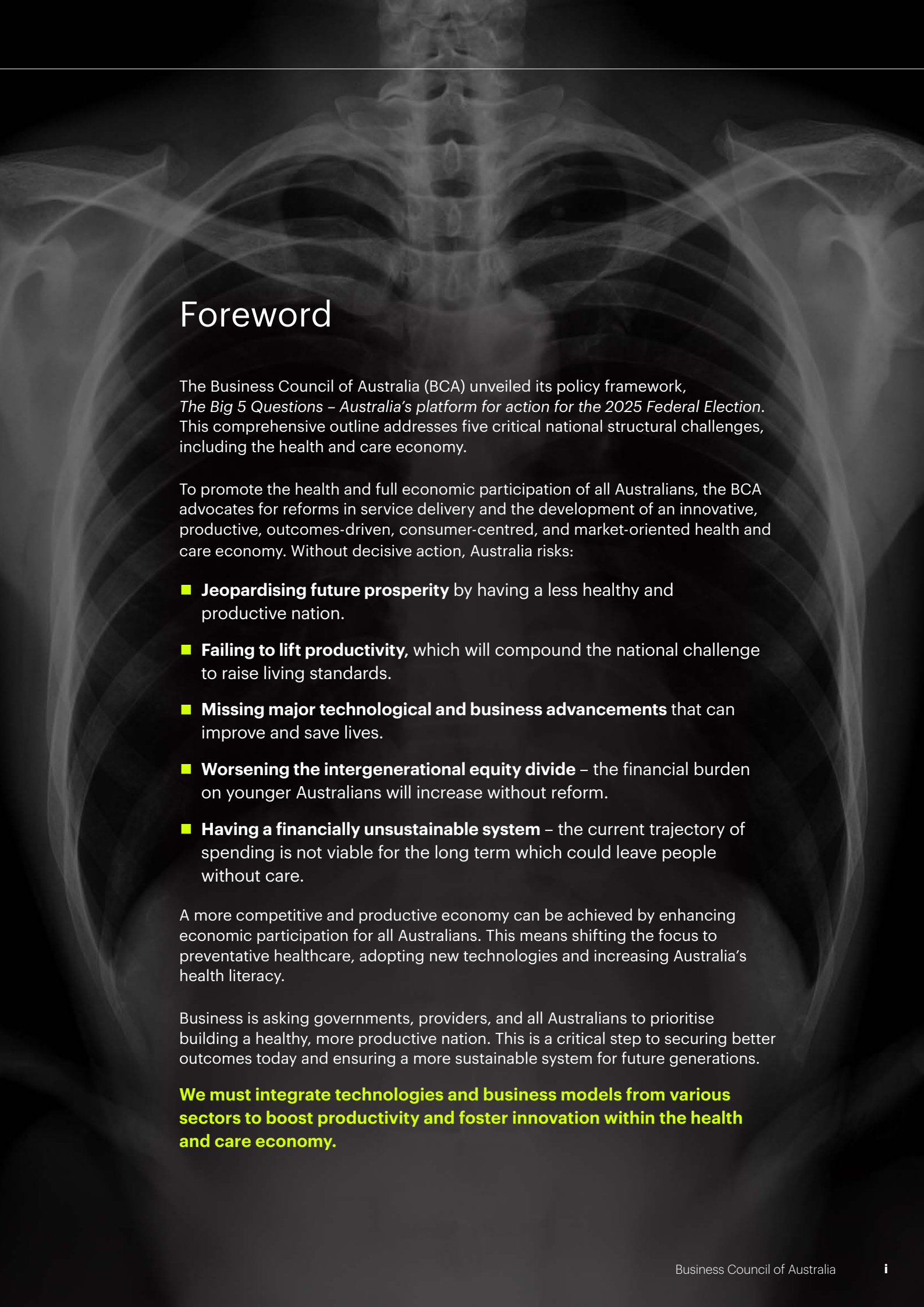


Foreword

The Business Council of Australia (BCA) unveiled its policy framework, *The Big 5 Questions – Australia's platform for action for the 2025 Federal Election*. This comprehensive outline addresses five critical national structural challenges, including the health and care economy.

To promote the health and full economic participation of all Australians, the BCA advocates for reforms in service delivery and the development of an innovative, productive, outcomes-driven, consumer-centred, and market-oriented health and care economy. Without decisive action, Australia risks:

- **Jeopardising future prosperity** by having a less healthy and productive nation.
- **Failing to lift productivity,** which will compound the national challenge to raise living standards.
- **Missing major technological and business advancements** that can improve and save lives.
- **Worsening the intergenerational equity divide** – the financial burden on younger Australians will increase without reform.
- **Having a financially unsustainable system** – the current trajectory of spending is not viable for the long term which could leave people without care.

A more competitive and productive economy can be achieved by enhancing economic participation for all Australians. This means shifting the focus to preventative healthcare, adopting new technologies and increasing Australia's health literacy.

Business is asking governments, providers, and all Australians to prioritise building a healthy, more productive nation. This is a critical step to securing better outcomes today and ensuring a more sustainable system for future generations.

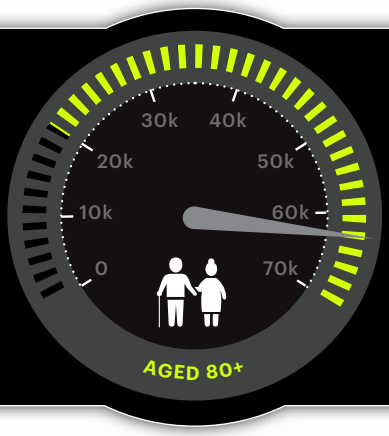
We must integrate technologies and business models from various sectors to boost productivity and foster innovation within the health and care economy.

Statistics

The number of **working age Australians** per retiree will fall from **4** to less than **3** within 40 years[1]

In 2022–23, the **gap between** Medicare levy **revenue** and Medicare benefits **expenditure** was approximately **$5.6B**[2]

Government **aged care expenditure** increased by **64%** between 2017–18 and 2023–24 rising from $22.1B to $36.4B[3]



Over the next 20 years, the average number of **people turning 80+** each year will be more than **60,000** compared to more than **20,000** the previous 20 years[4]

There is a **projected shortage** of **79,000** **nurses** by 2035[5]

The Australian **private health system** delivers **67%** of elective surgery and **41%** of all hospital admissions each year[6]

Top 5 growing government costs[7]

- Health
- Aged care
- NDIS
- Defence
- Debt interest

Australia's **care and support economy** set to nearly double from **8%** to **15%** of GDP in 40 years[8]

1 Commonwealth of Australia. (2023). *Intergenerational Report 2023 Australia's future to 2063.*
2 Commonwealth of Australia, Australian Taxation Office. Taxation Statistics; Commonwealth of Australia, *Budget Papers 2011-12 to 2023-24.*
3 Commonwealth of Australia, Australian Institute of Health and Welfare. (2025). *Spending on aged care.*
4 Australian Bureau of Statistics. (2024). *National, state and territory population.*
5 Commonwealth of Australia, Department of Health and Aged Care. (2024). *Nursing supply and demand projects.*
6 Commonwealth of Australia, Australian Institute of Health and Welfare. (2024). *Admitted patient care 2023-24.*
7 Commonwealth of Australia. (2023). *Intergenerational Report 2023 Australia's future to 2063.*
8 Commonwealth of Australia. (2023). *Intergenerational Report 2023 Australia's future to 2063.*

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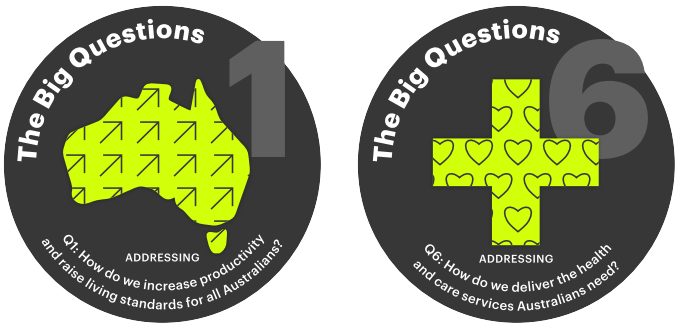
This report addresses key issues highlighted by the BCA, including:



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Executive summary

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Executive summary

Australia stands at a critical juncture in its health and care journey. With an ageing population, rising chronic disease, and increasing fiscal pressures, the sustainability of our health and care economy is under threat.

Blueprint outline

The Business Council of Australia (BCA) represents over 130 major employers, among them are members from health, aged care, insurance, research, and education sectors. Together, we present this blueprint as a comprehensive strategy to ensure a healthier, more productive nation.

This blueprint outlines a bold vision for a coordinated national approach to delivering a consumer-centred, outcomes-driven, and financially sustainable health and care economy. It focuses on two key pillars – health and aged care – while recognising the interconnectedness of disability, mental health, and veterans' services. The BCA calls for a whole-of-system reform that leverages the strengths of both public and private sectors, embraces innovation, and empowers individuals to take charge of their health. The BCA's recommendations are founded on six key principles.

1

Consumer empowerment

Empower consumers to choose how their care and support needs are met.

2

Financial sustainability

Implement reforms to support the financial sustainability of the health and care system, and to address intergenerational fairness in the context of an ageing population.

3

Innovation and technology

Capture the opportunities presented by evidence-based innovations and technologies, working with leading researchers to improve health and care outcomes and productivity.

4

A skilled workforce

Expand and sustain a highly skilled and trained health and care workforce to meet the needs of our population.

5

Complementary public and private systems

Build on the strengths of our complementary public and private systems to achieve the best outcomes.

6

A coordinated national approach

Take a unified approach to the long-term structural issues of the health and care economy. Reform cannot happen in isolation; it must consider the full continuum of care for consumers.

Recommendations

By embracing reform now, Australia can secure better health outcomes, greater economic participation, and a sustainable system for future generations. Our six overarching recommendations are supported by specific actions.

Overarching recommendations:

1

Empower consumers to manage their health and wellbeing by supporting consumer-centred care.

Empowering consumers to proactively manage their health and wellbeing, by responsibly addressing their needs and preferences, increasing transparency in services and utilising new technologies, will improve health literacy and outcomes.

2

Build a future health and care system to enable equitable access to services for all Australians.

Building a holistic approach to Australia's health and care economy will establish an adaptable, equitable, and sustainable system. This vision recognises new models of funding and service delivery, ensuring all Australians can access the essential services they need.

3

Invest in early intervention, research, innovation, and prevention to cultivate a healthy and more productive nation.

This focus will enable people to live healthy lives while reducing the financial burden on the health and care economy.

4

Strengthen the health and care workforce through adequate workforce planning and training to ensure it is productive and skilled.

Expanding our workforce by using new models of care and flexibility to adopt new innovations will be critical to meeting the demands of an ageing population and the increasing burden of disease.

5

Enable greater access to services by supporting a complementary and dynamic public and private health and care system.

Building an evolving and sustainable health and care market that fosters collaboration and dynamism between our complementary public and private systems will allow Australians to access quality and safe care.

6

Create a health and care system supported by a coordinated national approach, with improved accountability and coordination.

This strong coordinated approach will enhance governance, drive exceptional consumer outcomes and ensure the long-term sustainability of the system.

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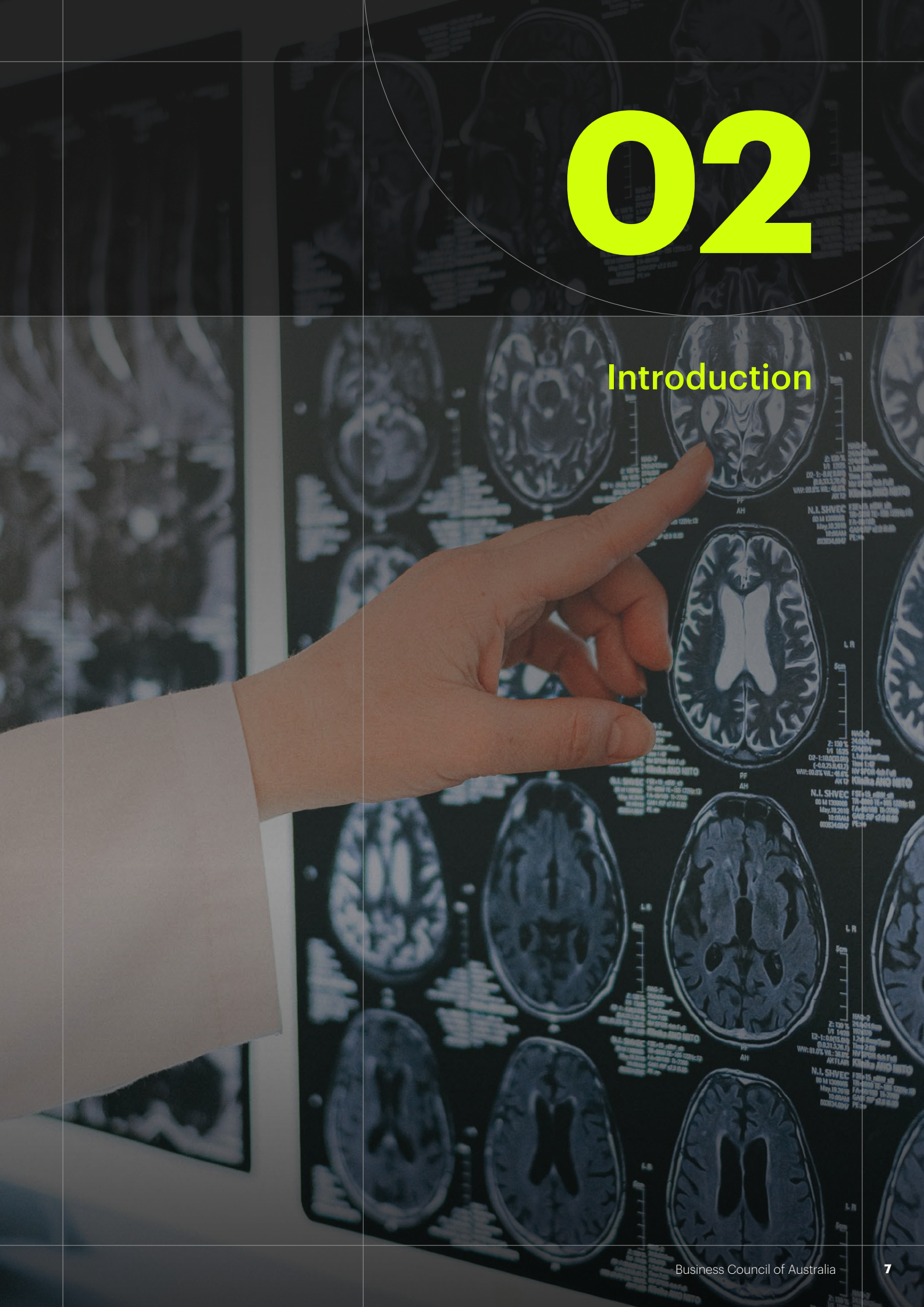
Introduction



02

Introduction

The growth of the health and care economy as a share of the overall economy will significantly impact national productivity, affecting the living standards of all Australians. We must address these key challenges to ensure we maintain and improve our current health and care system standing as well as our quality of life.

Reform for a healthy and productive nation

Like many other countries, Australia faces significant challenges in maintaining high living standards with cost-of-living pressures, demographic changes, and productivity challenges, which will impact growth and living standards.

Australia has long been recognised as a global leader, enjoying decades of prosperity and improving health and care outcomes. However, this progress is now at risk. Health and care are not merely social services – they are fundamental to our economy. Presently, the shortcomings within our health and care system risk undermining our economic opportunities.

The BCA's vision is for a globally competitive, productive, fair and inclusive economy. We seek to foster an economy that enhances the economic participation for all Australians, making Australia the best place in the world in which to live, learn, work and do business. Integral to this vision is a healthy and productive population, supported by a cost-effective, accessible and quality health and care system.

With an ageing population, an increasing burden of chronic disease, and a decreasing relative taxpayer base, we urgently need a renewed focus on the long-term funding of Australia's health and care system to ensure it is sustainable. The *Intergenerational Report 2023* and *Budget 2025-26* highlight a shrinking relative workforce, which exacerbates the nation's burden to fund health and care services for an ageing population.[1]

> **... we urgently need a renewed focus on the long-term funding of Australia's health and care system if it is to become sustainable.**

A significant reform agenda is essential to address these challenges. Reform will require people, processes, technology and cultural change. Governments can sponsor change, but all stakeholders, including providers, must deliver and embed these changes.

We must view improved health and care outcomes as a vital investment for our future, akin to education and research. By improving these outcomes, we can enhance the health of the nation, including productivity and economic participation. This involves proactively promoting physical and mental health and wellbeing by addressing the root causes of the current pattern of disease, and treating it cost-effectively, especially chronic conditions.

This blueprint focuses on two key areas: health and aged care. While the National Disability Insurance Scheme (NDIS) and veterans' affairs are also important components of the broader health and care economy, significant work has already been undertaken to address these areas, with further actions undoubtedly required. This blueprint provides a path forward for the health and care economy and outlines our view on what must be done to ensure our:

- Population remains healthy
- Health and care system remain financially sustainable
- Productivity improves.

The blueprint sets out how care is delivered and funded in Australia, provides global perspectives on how Australia compares to its international counterparts, and outlines the domestic challenges. Finally, it offers a range of recommendations and actions to overcome the challenges we face now and into the future.

This blueprint does not cover early childhood education and care (ECEC). We believe this sector is more appropriately addressed within the context of education and learning, alongside policy design aimed at increasing workforce participation, particularly for women.

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Understanding how care is delivered in Australia

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Understanding how care is delivered in Australia

Australia's health and aged care system is often considered a world leader. We rank highly on several global rankings, confirming that our unique framework delivers positive outcomes for Australians.

Supportive structure for all

Our system is not perfect, nor is it ideally structured to fully leverage upcoming innovative changes or manage the growing pressures from an ageing population. However, it provides a strong foundation from which we can drive essential reform.

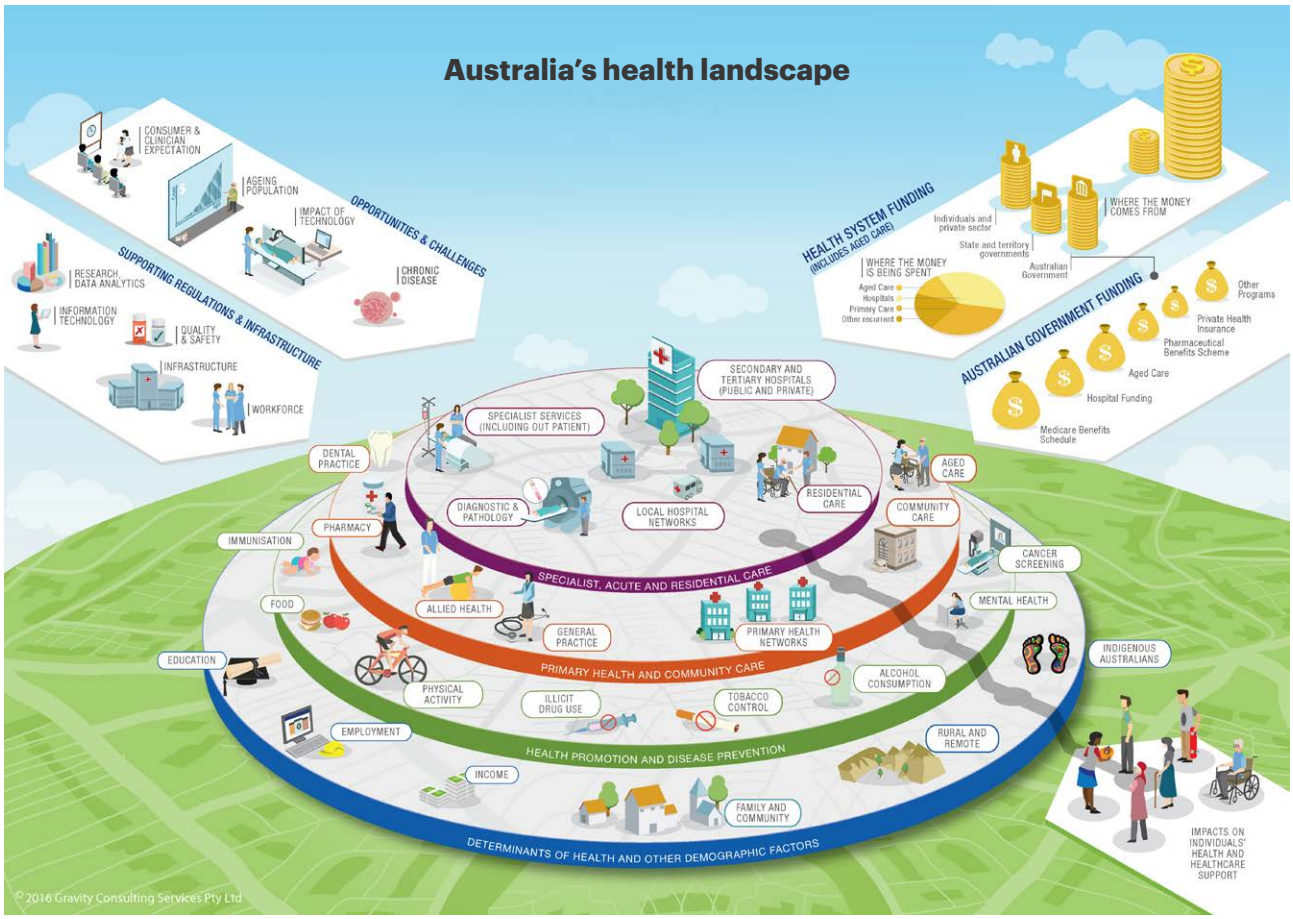
Our federated system is inherently complex, with responsibilities and funding divided between federal, state, territory and local governments, and service provision split between the private and public sectors (refer to appendix 1).

This complexity can lead to a lack of transparency which hinders the best consumer outcomes and true value for money (refer to figure 1). We also know accessing care for consumers can be confusing, time-consuming and costly.

3.1 Consumer

The consumer is the most important stakeholder and is central to the health and care system. Australians play a key role in influencing and shaping services and outcomes. Every Australian will access the health and care system at some point in their life, and our preferences and expectations of the system evolve year on year.[2]

Figure 1: Australia's health landscape



Source: Commonwealth of Australia, Department of Health, Disability and Ageing. (2017). *Australia's health landscape infographic.*

The concept of consumer-centred care has been around for over a decade, but a fragmented system and inefficient funding models have made it hard for consumers to access and navigate their care.

However, consumer experiences can drive improvements and foster a greater understanding of effective and quality care.[3] Consumer feedback enables policy and research to be undertaken, ensuring the system remains responsive to the population's needs.

Consumers are also increasingly active in managing their health and care, particularly with the rise of technology. They are becoming more informed and empowered. A collaborative approach will enable individuals to have shared decision-making, choice, ownership and responsibility, which will lead to improved outcomes.[4] Active participation will help the system become more inclusive and effective in serving its purpose.

3.2 Primary care

The primary care system forms the foundation of Australia's health and care system. Common services include general practice, pharmacies, nursing services, oral health and dental services, mental health, drug and alcohol services, and allied health services such as psychologists and physiotherapists.[5] It enables Australians to receive first-contact, accessible, continuous, comprehensive and coordinated care.[6]

Primary care also supports broader strategic objectives such as optimising population health and reducing health disparities and inequalities.[7] It is provided at the community level and serves as the gateway for ongoing care and referral to more specialised services.[8] It is a key connection for older Australians managing their health and aged care needs. These services are usually delivered by small private businesses or coordinated and commissioned by Primary Health Networks (PHN).

3.2.1 General practice

General practitioners (GP) have long been the crucial coordinators within the Australian health and care system, acting as the initial point of contact for many Australians (outside of emergency departments).[9]

It is the role of GPs to coordinate and manage an individual's care and to provide referrals to specialists as required.[10] They offer diagnosis and treatment for a wide range of health conditions and provide long-term care.[11] People can consult a GP via a practice, telehealth, some hospitals, residential aged care facilities, or through home visits.[12]

General practices are typically small businesses and are not usually run or commissioned by government (except for Urgent Care Clinics). There are more than 7,000 accredited general practices in Australia, with between 35,000 to 40,000 GPs in the primary care workforce.[13] GPs are specialist doctors who have completed training in general practice, typically involving 10-15 years of education (degree, internship and specialist training) before they can work independently.[14]

3.2.2 Pharmacies

Pharmacists play an important role in the primary care system, providing access to much-needed services. Their key role involves the custody, preparation, dispensing and provision of medicines.[15] Pharmacists can also offer advice on minor health conditions, help manage chronic conditions and advise when a consumer should see a doctor.[16]

Pharmacies are generally small businesses and are not typically run by government. There are close to 6,000 community pharmacies and nearly 40,000 registered pharmacists across Australia.[17] Pharmacists are trained and registered health professionals who undertake a four-year degree, an internship, and then receive general registration.[18]

3.2.3 Dentistry

Dentists and dental practitioners (including hygienists, therapists, and prosthetists) help people care for their teeth and gums, as well as the health of the muscles and bones in the mouth.[19] Oral health is fundamental to supporting an individual's overall health and wellbeing.[20]

Dental practices are typically small businesses and are not run by government (except for public dental services). There are approximately 7,000 private dental practices and 28,000 dental practitioners across Australia.[21] Generally, dentists undertake a seven-year degree, internship and then receive general registration.[22]

3.2.4 Nursing

Primary care nurses play a critical role in disease prevention and control to keep consumers healthy by providing proactive care and health promotion.[23] They will play an important role as the health and care system grapples with an ageing population.

Nurses (including enrolled nurses, registered nurses, and nurse practitioners) are the largest clinical workforce, with more than 500,000 across Australia.[24] In particular, primary healthcare nurses are the largest group of healthcare professionals working in primary care (including community health, general practice, aged care, and schools) with approximately 98,000 across Australia.[25]

3.2.5 Other allied health

There is no universally accepted definition of allied health, but broadly, these professionals are not part of the medical, dental or nursing professions.[26] A wide range of allied health services are offered to Australians within the primary care setting, including physiotherapy, psychology and social work.

Allied health professionals provide a range of diagnostic, technical, therapeutic and direct health services to improve people's health and wellbeing.[27] Allied health is one of the fastest-growing areas within the health and care economy, encompassing specialties such as occupational therapy, osteopathy and physiotherapy.[28] These professionals will play a more important role across our health and care system as we increasingly rely on multidisciplinary teams.

Allied health practices are typically small businesses and are not run by government. There are more than 300,000 registered allied health professionals across Australia, who generally hold a university qualification and in most cases are accredited by a national accreditation body.[29] These professionals are also likely to be practising in tertiary hospitals and in aged care settings.

3.2.6 Primary Health Networks

There are 31 Primary Health Networks (PHN) funded by the Australian Government and operated by independent organisations.[30] Their role is to improve the delivery of primary care in their region, ensuring the community's local health priorities are met by coordinating and streamlining services, and minimising gaps or duplication.[31]

PHN key functions include coordinating and integrating local health services in collaboration with Local Health Networks, commissioning primary care and mental health services, building capacity and providing practice support to those services.[32] They also support health services to connect with each other to improve people's care and strengthen the overall primary healthcare system.[33]

3.3 Secondary and tertiary care

While general practice serves as a crucial gateway, secondary and tertiary care – involving specialists and public and private hospitals – is a cornerstone of the Australian health and care system.

- Secondary care involves an individual being referred from the primary care setting to a specialised service.
- Tertiary care focuses on treating people when they reach an acute stage, requiring highly specialised services for a complex condition, rather than taking a preventative approach.

The blend of both public and private services is a distinct feature of Australia's health and care system.

3.3.1 Medical specialists

Medical specialists play a critical role in providing services to all Australians. They are responsible for diagnosing and treating physical and mental conditions, recommending preventative action and referring consumers to other services.[34]

Medical specialist practices are typically small businesses and are not run by government. There are more than 140,000 registered medical practitioners, of whom nearly 90,000 were specialists (including GPs).[35] They generally work out of 'doctors' rooms' in the community and may perform services within their rooms or in a clinical or hospital setting.

Like GPs, specialists complete at least four years in a university medical school accredited by the Australian Medical Council, followed by a 12-month internship to gain general registration.[36] Specialists then spend several years training in a medical specialty such as surgery or psychiatry.[37]

3.3.2 Public hospitals

In Australia, public hospitals are owned and run by state and territory governments, with co-funding from the Australian Government.[38] Some public hospitals are operated by private providers through arrangements with state and territory governments.[39] As of 15 July 2025, there were 698 declared public hospitals (52 per cent of all hospitals).[40] In 2023-24, public hospitals accounted for approximately 7.5 million hospital admissions (59 per cent) and 800,000 elective surgeries (33 per cent) (refer to figure 2).[41]

They are generally clustered into regions, sometimes known as Local Health Networks. Public hospitals provide emergency departments, admitted settings (such as medical, surgical, or maternity) and non-admitted community services (such as mental health, and drug and alcohol support).[42]

3.3.3 Private hospitals

Private and not-for-profit hospitals are operated by a full range of private sector organisations, with funding provided by governments, private health insurers and consumers.[43] As of 15 July 2025, there were 632 private hospitals in Australia (48 per cent of all hospitals).[44] In 2023-24, private hospitals accounted for approximately 1.7 million elective surgeries (67 per cent) and 5 million hospital admissions (41 per cent) (refer to figure 2).[45] They enable Australians to choose their own doctor, enjoy shorter elective surgery wait times and access additional services.[46]

The Australian Government does not directly fund private hospitals unless there are specific arrangements between a public and private hospital.[47] The private sector owns and runs these facilities. The Australian Government does subsidise private health insurance for Australians who choose to take it out for extra health cover.[48]

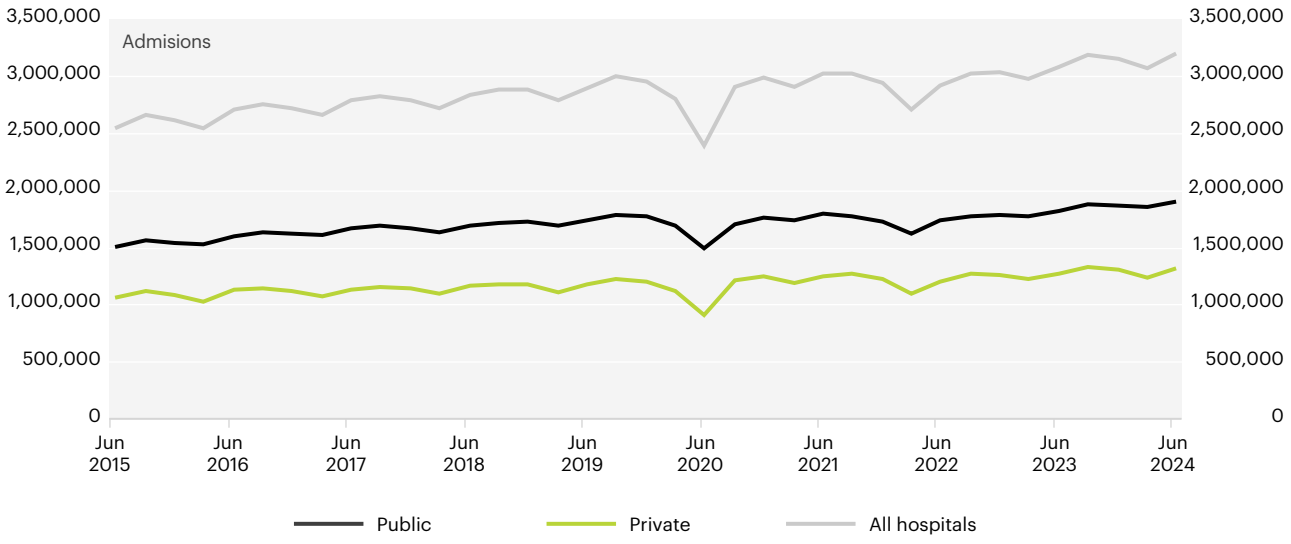
3.4 Mental health

Mental health services are delivered across the primary, secondary, tertiary and aged care settings by both the public and private sectors. Many services are offered in the community and private settings by GPs, medical specialists, psychologists and other allied health professionals, often supported by Australian Government funding.[49]

State and territory governments also provide these services through a range of facilities (emergency departments, specialised services, public hospitals) designed to offer immediate and ongoing support.[50] The private sector, including hospitals, also delivers a range of services which usually complement government funded services.[51]

The community sector also plays a crucial role in providing a range of services, including crisis and support services, such as Lifeline and Beyond Blue.[52]

Figure 2: Public hospital vs private hospital admissions, June 2015 to June 2024



Source: Commonwealth of Australia, Australian Institute of Health and Welfare. *Admitted patient care data 2015 to 2024.*

3.5 Health and medical technology

Australia has an advanced health and medical technology industry, including significant manufacturing capabilities. Our technologies cover everything from prevention and diagnostics to treatments and health promotion. Technologies encompass medicines, vaccines, medical devices and tests.[53] In a digital world, they also include electronic health records, electronic prescriptions and remote monitoring.[54]

Health and medical technology are delivered through a changing and often complex system that involves public and private collaboration. Rapidly changing technologies enable a range of new services to be offered and delivered virtually for consumers.

These technologies are mostly designed and developed by businesses that work closely with governments, the private sector more generally, and universities. It is estimated there are 17,000 Australians directly employed and a further 34,000 Australians indirectly employed in the medical technology industry.[55]

Funding is typically provided by the Australian Government (through Medicare and the Prescribed List), state and territory governments or private health insurance.[56] The Australian Government's Therapeutic Goods Administration (TGA) regulates the approval and supply of such technologies, particularly of medicines and devices including medical gloves, bandages, X-ray equipment and pacemakers.[57]

3.6 Health and medical research

Health and medical research plays a crucial role in advancing our capabilities and delivering improved outcomes. This research spans the entire health and care system in Australia – from primary, secondary and tertiary care to aged care and the community setting. It also plays a crucial role in developing and commercialising new technologies and models of care.

Broadly, the National Health and Medical Research Council (NHMRC) oversees the governance of research in Australia.[58] Researchers can be employed by governments, universities, hospitals, institutions and businesses, and their work can take many forms, including clinical trials.[59]

There are nearly 40,000 researchers employed in the Australian health and medical research workforce, with 65 per cent employed in traditional settings (such as universities and medical research institutes), while the remaining 35 per cent are employed in the private sector and clinical roles.[60]

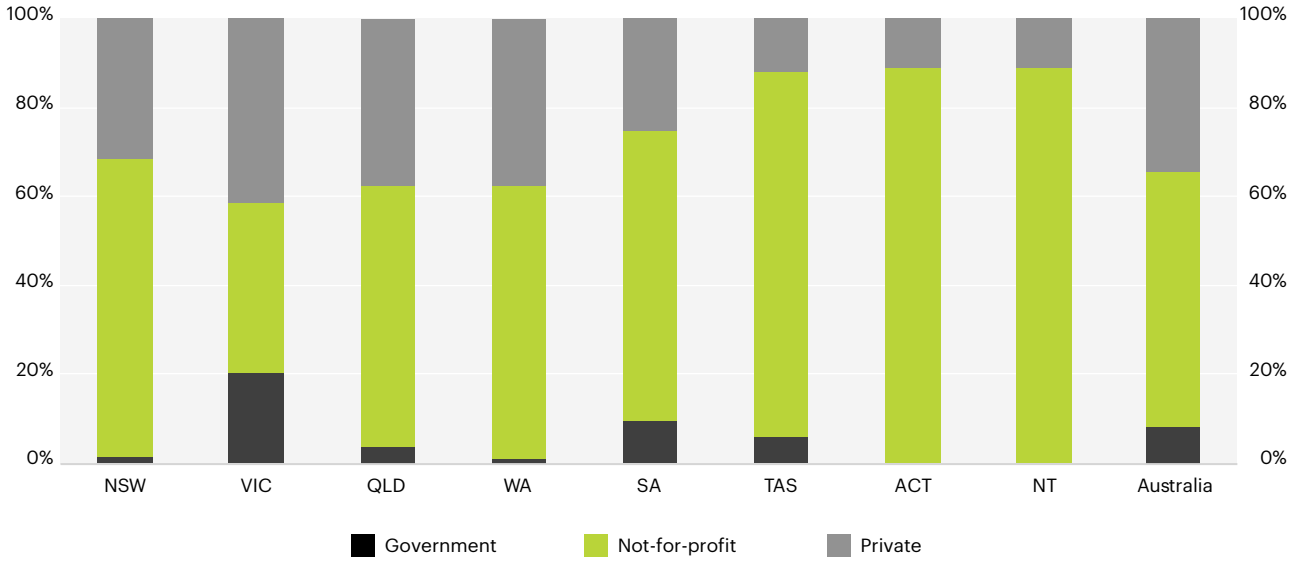
3.7 Aged care

Aged care refers to the support provided to older people who need help in their own home or who can no longer live at home, including assistance with everyday living, equipment, personal care and accommodation.[61] As Australians grow older, our aged care sector will face extraordinary pressures to meet demand.

From 1 November 2025, the new *Aged Care Act 2024* (Cth) and the Support at Home Program will commence, aiming to place older Australians at the centre of the system.[62] These reforms are also a direct response to the *Royal Commission into Aged Care Quality and Safety*, which highlighted very serious systemic issues.

There are a range of different settings in aged care, including home care, residential aged care, short-term respite care and retirement homes.[63] There are over 3,000 aged care providers delivering care through 9,100 services.[64] Many of these providers are private sector and not-for-profit, and are not run by government. The private and not-for-profit sector operates 94 per cent of home care services, 92 per cent of residential care services and 82 per cent of home support services (refer to figure 3).[65]

Figure 3: Residential care services by organisation type and state/territory, 30 June 2023



Source: Commonwealth of Australia, Australian Institute of Health and Welfare. (2025). GEN Aged Care Data – *Providers, services and places in aged care.*

3.8 Disability

While this blueprint does not primarily focus on disability; it is important to provide context as disability services are interconnected with the health and aged care system. People with disability may have associated health conditions and all governments, plus the private sector, play a role in delivering support.[66]

Many services were once delivered by state and territory governments, but this shifted in 2013 when the Australian Government established the NDIS.[67] It is important to note other disability services do remain and continue to be delivered by different organisations.

A significant policy change, the NDIS provided much-needed support for Australians with permanent and significant disability that affects their ability to take part in everyday activities, including funding to build capacity, increase independence and promote social and economic participation.

The NDIS is jointly funded by the Australian, state and territory governments and is administered by the National Disability Insurance Agency (NDIA).[68] Services are typically delivered by businesses and community providers, while state and territory governments may offer or fund other disability services.[69]

The NDIS has become a major disrupter across the health and care system and the economy more broadly, due to its growth, cost and the way it has drawn resources away from health and aged care providers, including workers.

We recognise the Australian Government's recent announcement to change NDIS eligibility criteria and to establish the Thriving Kids program which will provide children with mild to moderate developmental delay or autism with specific support services.[70]

Further tensions have arisen between governments regarding different policy and care settings.[71] This is important to consider when reading the recommendations. We must approach reform at a system level, ensuring all health and care systems work hand in hand.

3.9 Veterans

Ex-Australian Defence Force personnel have played an important role in our security and prosperity. As such, our veterans receive comprehensive care and support, including health, aged care, mental health and disability services.

These services are generally delivered through a coordinated system led by the Department of Veterans' Affairs, in partnership with state and territory governments, business and community

providers.[72] The *Royal Commission into Defence and Veteran Suicide* will continue to play a role in shaping policy and the future system to ensure the health and care needs of the veteran population are addressed.

Typically, these services are funded by the Department of Veterans' Affairs and commissioned separately to the Department of Health, Disability and Ageing.[73] While this blueprint does not specifically focus on veterans' health, it is important to consider the funding arrangements and structures of our systems to ensure they can remain healthy and productive.

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How is care funded in Australia?

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How is care funded in Australia?

Australia's health and care funding system is highly complex, and for that reason, the public has limited understanding of its true costs and sources. It is true Medicare eligibility is a consumer's 'ticket' to being treated as a public patient in a public hospital.[74]

Funding costs and sources

Some believe Medicare funds public hospitals, when in fact, it largely funds health services provided in the private setting, such as general practice and specialist care.[75]

Many believe the Medicare levy covers the full cost of running our health system. It does not. In 2022-23, the gap between Medicare revenue and Medicare Benefits Schedule (MBS) expenditure was approximately $5.6 billion (refer to figure 4).[76]

Broadly, public hospitals are funded via other means, such as the National Health Reform Agreement (NHRA) between the Australian Government and state and territory governments.[77]

Other revenue sources are also needed to fund aged care, the Pharmaceutical Benefits Scheme (PBS) and the NDIS.

Between 2011-12 and 2023-24, Australian Government expenditure alone on health, aged care and the NDIS increased from approximately $70 billion to $184 billion (refer to figure 5).[78] This figure does not include expenditure from state and territory governments, private health insurance or consumer contributions.

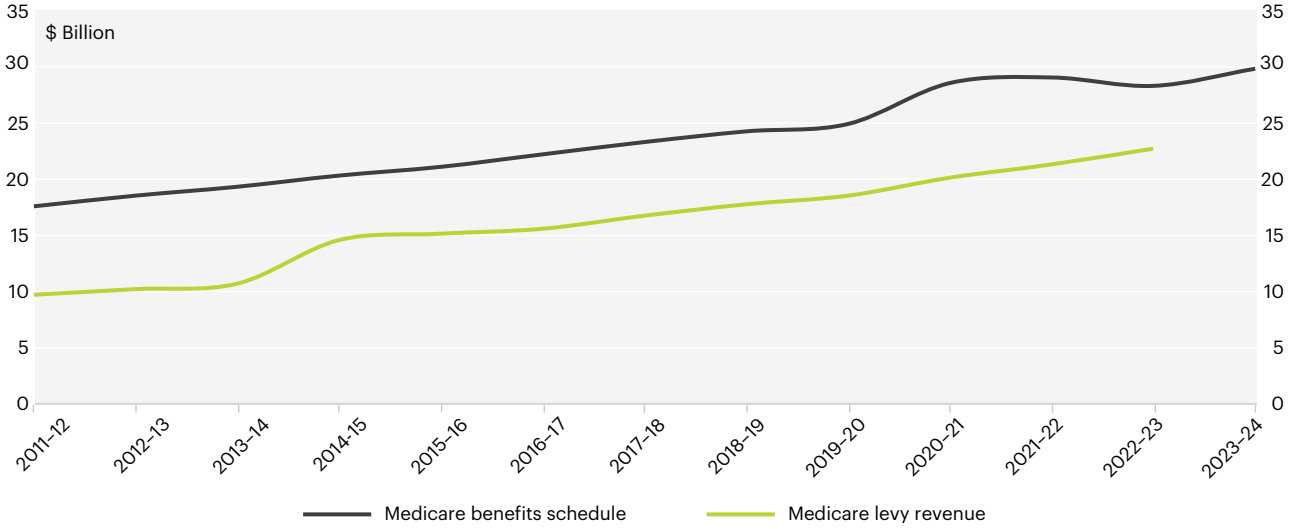
To implement effective policy reform and ensure we have the right settings in place, it is important to understand how services are funded, including what is, and is not, covered.

4.1 Health funding overview

In 2022-23, Australia spent an estimated $252.5 billion on health goods and services, and governments contributed $178.7 billion of total health expenditure (70.8 per cent).[79] The Australian Government contributed $101.5 billion, and state and territory governments contributed $77.3 billion.[80] The remaining $73.8 billion (29.2 per cent) came from non-government sources, including:[81]

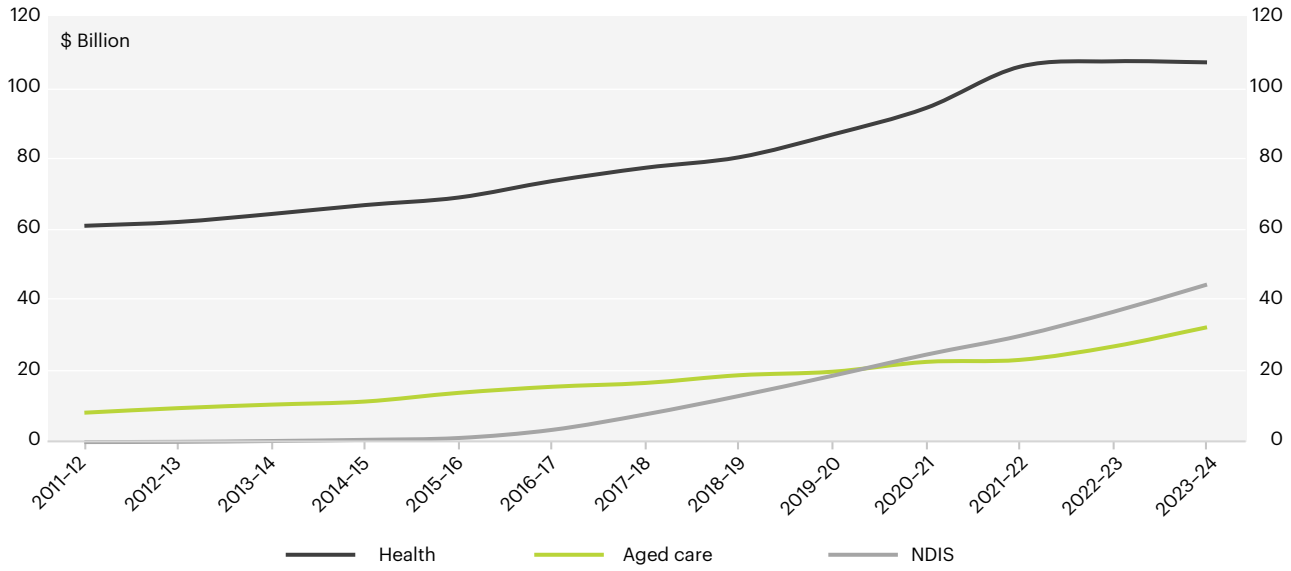
- Individuals, who contributed $38.9 billion, just over half (52.6 per cent) of non-government health spending.
- Private health insurance providers, who contributed $19.3 billion (26.2 per cent).
- Other non-government sources, who contributed $15.6 billion (21.1 per cent).

Figure 4: Medicare benefits expenditure compared to Medicare levy revenue, 2011-12 to 2023-24



Source: Commonwealth of Australia, Australian Taxation Office. *Taxation Statistics;* Commonwealth of Australia, *Budget Papers 2011-12 to 2023-24.*

Figure 5: Health, Aged care and NDIS Expenditure, 2011-12 to 2023-24



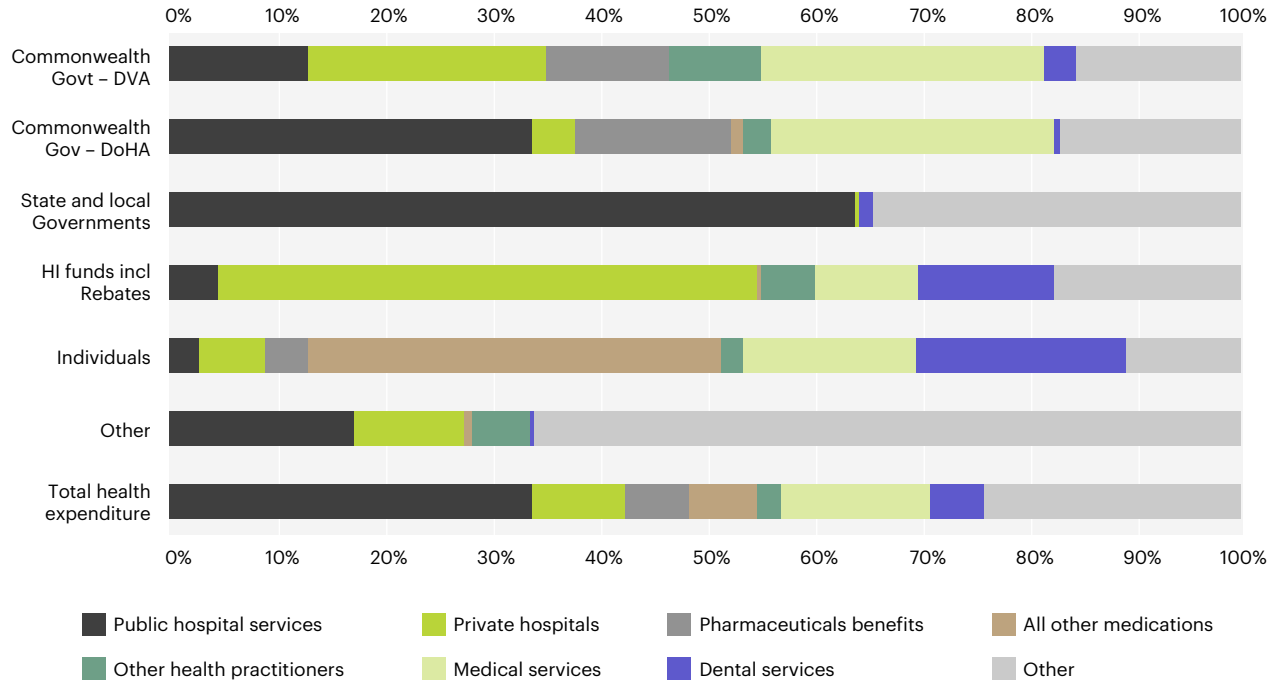
Source: Commonwealth of Australia, *Budget Papers 2011-12 to 2022-23.*

Hospitals received $107.1 billion (42.4 per cent) of this health spending, followed by primary care at $83.3 billion (33 per cent).[82] A total of $21.3 billion (8.4 per cent) went to referred medical services, and $40.8 billion (16.2 per cent) was spent on other services including research and capital.[83]

Between 2021-22 and 2022-23, hospital expenditure rose $4.8 billion (4.7 per cent) after adjusting for inflation, in response to increased hospitalisations.[84] However, there was a $7.5 billion decrease (8.2 per cent) in real terms in the primary care system during the same period, mainly due to COVID-19 vaccines and personal protective equipment.[85]

Recent budget papers also indicate the various sources of health expenditure by payer and

Figure 6: Australia's recurrent health expenditure by payer and service – 2022-23 (share of health care expenditure)



Source: Commonwealth of Australia, Australian Institute of Health and Welfare. (2024). *Health expenditure Australia 2022-23*; Commonwealth of Australia, *Budget Papers 2022-23.*

Table 1: Overview of services covered by Medicare

Covered	Not covered
■ Services delivered in public and private hospitals ■ Medical services by doctors, specialists and other health professionals, such as seeing a GP or specialist including eye tests by optometrists ■ Hospital treatment ■ Prescription medicines, if covered by the Pharmaceutical Benefits Scheme ■ Mental healthcare ■ Tests, scans (such as x-rays) and preventative screening programs	■ Ambulance services (covered by some state governments or private cover) ■ Elective surgery and cosmetic surgery ■ Private patient costs in hospital ■ Extra services such as dental and physiotherapy ■ Medical aids such as glasses, contact lenses or hearing aids ■ Services not on the Medicare Benefits Schedule ■ Services provided through the private health system

Source: Commonwealth of Australia, Department of Health, Disability and Ageing. (2024). *What Medicare covers*; Commonwealth of Australia, Services Australia. (2024). *Health care and Medicare*.

service (refer to figure 6). This highlights the true complexity of healthcare funding in Australia. It is not as simple as people think.

Public hospitals make up nearly 35 per cent of Australian Government health expenditure and more than 60 per cent of state and territory government health expenditure.[86] Private hospitals account for approximately 50 per cent of private health insurance (and associated rebates) expenditure, with other medications (not listed on the PBS) making up 40 per cent of individual health expenditure.[87]

4.1.1 Medicare

Established in 1984, Medicare is Australia's universal health insurance scheme.[88] Partially funded by taxpayers and other government revenue sources, it provides basic healthcare for all Australians, including payments for some services and medicines at low or no cost.[89] It aims to provide equitable access to healthcare for Australians, regardless of where they live or their ability to pay.[90]

Medicare may cover chronic health conditions (under a chronic disease management plans), mental health conditions (under a mental health treatment plan) and some allied health services, while others might be covered by private health insurance policies (refer to table 1).[91]

Government funding varies. Typically, a limited number of sessions are covered, or a portion of the cost will be covered via a subsidy or rebate, with the remainder paid by the consumer.[92] Many of these services will be important as Australians age and need assistance with maintaining mobility.

Separately, there are other government-funded services such as public dental services and specific targeted programs for children or those receiving government benefits.[93] They are generally delivered by state governments, such as the Sydney Dental Hospital.

Broadly, Australians covered by Medicare are entitled to:[94]

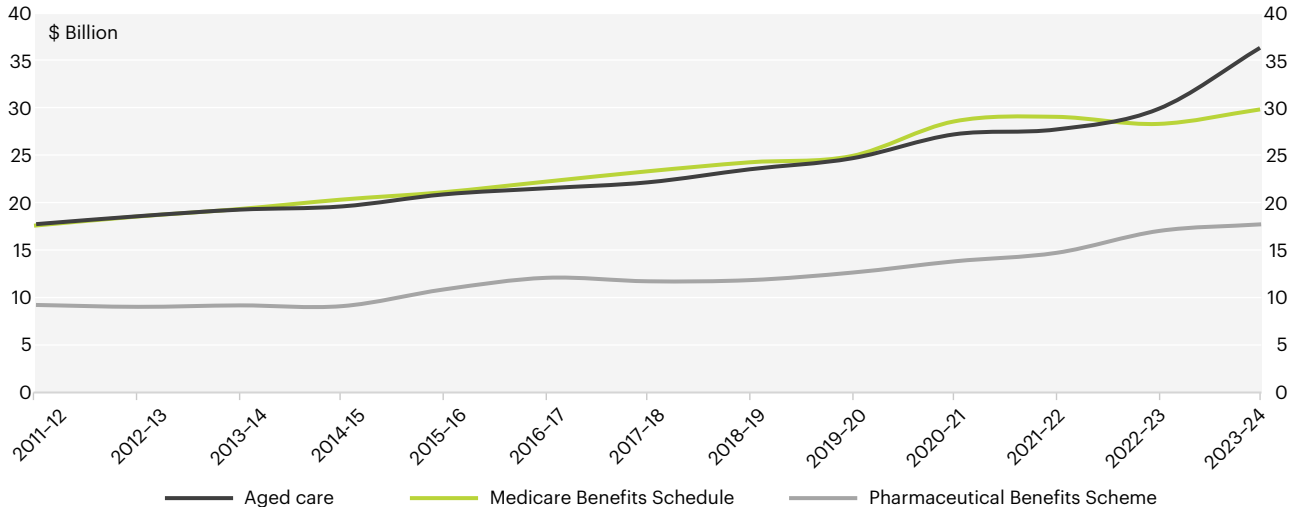
- Free treatment as a public patient in a public hospital.
- Doctor visits and some medical tests in the private setting, partly or fully paid for by Medicare.
- Reduced cost for prescription medicine, subsidised by the PBS.

4.1.1.1 Medicare Benefits Schedule

Under Medicare, the Australian Government sets benefits that are paid via the MBS.[95] This schedule provides a list of fees for medical services which is managed by the Department of Health, Disability and Ageing.[96] Generally, Medicare covers 85 per cent of the schedule fee for out-of-hospital services and 75 per cent for in-hospital services.[97]

Over the past decade, government MBS expenditure has steadily increased year on year.

Figure 7: Expenditure for Aged Care vs Medicare Benefits Schedule vs Pharmaceutical Benefits Scheme, 2011-12 to 2023-24



Source: Commonwealth of Australia, *Budget Papers 2011-12 to 2023-24*.

Between 2011-12 and 2023-24, MBS expenditure nearly doubled from $17.5 billion to almost $30 billion (refer to figure 7).[98] Despite this significant investment, recent data confirms Australians are increasingly paying more out-of-pocket costs for health and care services as Medicare does not cover all fees.[99] Addressing this growing financial burden on consumers will be addressed later in this blueprint.

4.1.1.2 Medicare levy and medicare levy surcharge

Australians contribute to the national health system through a Medicare levy, paid in addition to income tax. The levy is currently set at 2 per cent of an individual's taxable income, with specific reductions and exemptions depending on personal circumstances.[100]

To encourage the use of the private health system and ease pressure on public services, Australians are also incentivised to take out private health insurance. An additional Medicare levy surcharge (MLS) of 1 to 1.5 per cent is applied if consumers do not have appropriate private hospital cover and earn above an income threshold, effectively increasing their total Medicare contributions.[101]

In 2022-23, the Medicare levy and the MLS generated $22.7 billion in revenue.[102] The revenue continues to increase, more than doubling the amount from 2011-12.[103] While this growth reflects Australians, in part, earning more and paying more income tax, our health and care system remains financially strained.

The MLS revenue alone increased from about $247 million in 2011-12 to more than $1 billion in 2022-23.[104] This rise has occurred despite the number of Australians holding private health insurance remaining relatively steady over this time period.[105] This trend reflects a mix of either an increase in the number of Australians without appropriate cover, a growing workforce, and the impact of bracket creep. We need to better understand whether consumers truly value private health insurance compared with public options, and how their cost decisions reflect this perception.

The Australian taxation system heavily relies on individual income taxes, which generate $283 billion.[106] This is followed by company taxes on businesses, which generate $175 billion, and the government health insurance levy, contributing more than $22 billion.[107]

Other sources of government revenue and individual contributions are indispensable for funding these services. With an ageing population, demand is projected to continue its significant growth.

As mentioned, the Medicare levy and MLS does not fully cover Medicare expenditure (a gap of $5.6 billion), let alone other essential services such as the PBS, public hospitals, aged care or the NDIS. While this was not the original intent of the levy, it is an important consideration in our current fiscally constrained environment.

If we were to include Australian Government public hospital expenditure, this gap would

increase to more than $30 billion when compared solely to Medicare revenue.[108] Furthermore, if we were to broaden this to include all health and care expenditure, encompassing the PBS, aged care and the NDIS, a $100 billion gap would exist relative to Medicare revenue.[109]

4.1.1.3 Private health insurance and rebate

Australians can choose to take out private health insurance to cover costs not necessarily covered by Medicare. The Australian Government provides a rebate to help with the cost of this insurance, which is paid directly to private health insurers.[110] Since 2011-12, Australian Government rebate payments have risen from $5 billion to more than $7 billion in 2023-24.[111]

Private health insurers offer various levels of cover. In 2019, the Australian Government reformed the structure of policies to provide greater consistency and transparency, aiming to help consumers more easily choose the right cover for their needs.[112] The standard levels of cover include Gold, Silver, Bronze and Basic.[113]

Private health insurance also provides individuals with the choice of their treating doctor and whether they are treated as a private or public patient.[114] Depending on their level of cover, they may need to pay an out-of-pocket amount, or excess.[115]

The number of Australians holding some type of private health insurance continues to increase year on year, for both hospital and general treatment policies. As at March 2025, nearly 12.5 million Australians had hospital treatment cover, with an additional 2.7 million Australians holding general treatment only (refer to figure 8).[116]

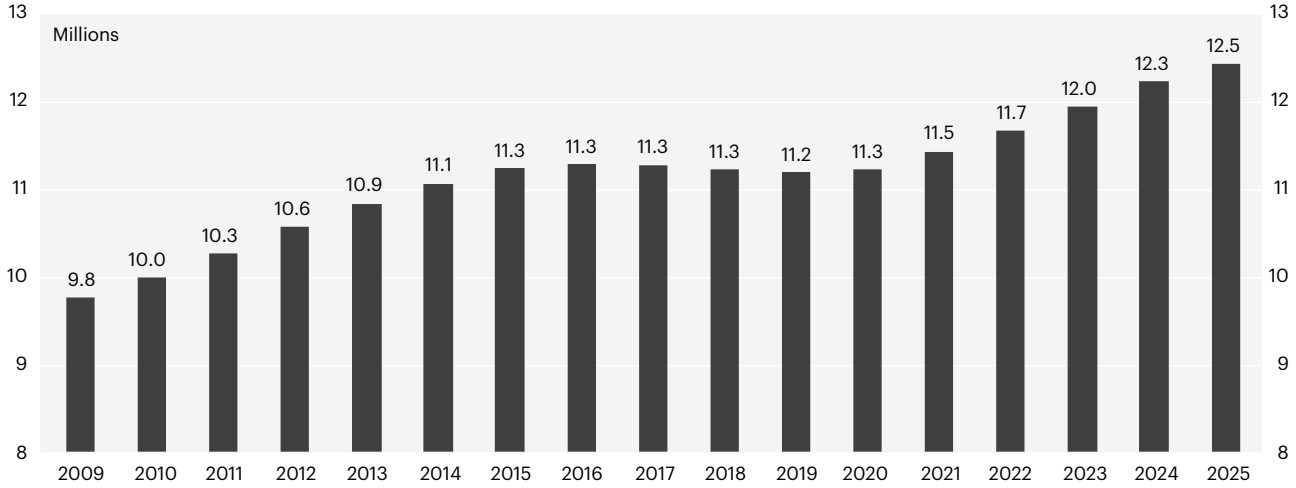
Private health insurers offer general treatment cover (also known as 'extras' cover), which can help cover the costs of services generally not covered by Medicare, such as dental care, physiotherapy and non-PBS pharmaceuticals.[117] For most Australians, private health insurance is the primary mechanism through which they cover dental costs, given the limited funding for dental and oral services under Medicare.[118] Other services often covered include optometry and various allied health services, such as physiotherapy.[119]

Beyond the government private health insurance rebate, consumers also contribute significantly to their private health insurance membership. In 2023-24, insurance revenue was estimated to be nearly $31 billion.[120] Between 2018-19 and 2023-24, private health insurance benefit payments have continued to increase, with approximately $24.4 billion paid out in 2023-24.[121]

4.1.2 Pharmaceutical Benefits Scheme

Established in 1948, the PBS initially provided free medicines for pensioners and a list of 139 life-saving and disease-preventing medicines.[122] Today, it stands as a cornerstone of the Australian Government's broader National Medicines Policy, aiming to give Australians affordable and safe access to essential medicines.[123]

Figure 8: Number of Australians with private health insurance, 2009 to 2025



Source: Commonwealth of Australia, Australian Prudential Regulation Authority. *Annual private health insurance statistics 2009 - 2024;* Commonwealth of Australia, Australian Prudential Regulation Authority. (2025). *Quarterly private health insurance statistics.*

The PBS is managed by the Australian Government Department of Health, Disability and Ageing and administered by Services Australia.[124]

The PBS also aims to provide medications and services that improve health and deliver value for money.[125] Most medicines are dispensed by pharmacists for use at home, though, some are only accessible at specialised medical services.[126]

Since 2011-12, PBS expenditure has almost doubled from $10 billion to nearly $19 billion (refer to figure 6).[127] In 2023-24, the government spent $17.6 billion on the supply of medicines, representing 91.6 per cent of total medicine costs.[128] Australians contributed $1.6 billion, or 8.4 per cent.[129]

As of 30 June 2024, 930 medicines across 5,164 brands were listed on the PBS.[130] More than 226.5 million subsidised prescriptions were dispensed.[131] Of these, 199 million prescriptions (88 per cent) were for concession card holders at a cost of $10.8 billion, compared with 27.1 million prescriptions (12 per cent) for general patients at a cost of $6.8 billion.[132] This largely indicates that the medication costs of Australians who hold a concession card are greater than those of the general population because the government covers more of the cost.

Moreover, more PBS prescriptions are dispensed as a consumer ages. Most prescriptions (63 per cent) were for people aged 60 and over, totalling $10.5 billion (59.6 per cent) of total government spending on medicines ($17.6 billion).[133] With an ageing population and increasing chronic conditions, we anticipate costs for medicine will continue to increase.

Furthermore, the Eighth Community Pharmacy Agreement (8CPA) supports the Australian Government deliver the National Medicines Policy.[134] This is an agreement between the Minister for Health, Disability and Ageing and the Pharmacy Guild of Australia. Under the latest Agreement, the overall funding envelop over five years is $26.44 billion, comprising of $24.6 billion for dispensing remuneration, $1.3 billion for programs, and $489 million for other policy commitments.[135]

4.2 Aged care

With our ageing population, expenditure on aged care represents one of the major growth areas in the federal budget. Government expenditure increased by 64 per cent between 2017–18 and 2023–24, rising from $22.1 billion to $36.4 billion (refer figure 6).[136] This represents an exponential and unsustainable rate of growth. It also included significant additional funding in response to the *Royal Commission into Aged Care Quality and Safety*.

The Australian Government is the primary funder of aged care services, providing approximately 99 per cent of government expenditure.[137] In 2023-24, government spent $21.5 billion on residential care services, $11.5 billion on home care and support services, $1.1 billion on flexible care services, and $2.3 billion on other services (refer to figure 9).[138]

In 2023-24, residential aged care recipients contributed about 22 per cent of revenue received by residential aged care providers, whereas home care recipients contributed approximately 2.8 per cent of revenue received by home care providers.[139]

The Australian Government provides subsidies to support and care for older Australians through various programs, including:[140]

- Entry-level home support services, such as transport and meals, delivered through the Commonwealth Home Support Program.
- Comprehensive home-based care, such as cleaning and personal care, provided through home-care packages.
- Residential aged-care services that offer 24-hour care and accommodation for older people no longer able to stay in their own home.
- Other targeted programs and services, such as Transition Care, Short-term Restorative Care, the Multi-purpose Services Program, the Innovative Care Program, Aboriginal and Torres Strait Islander Programs and Department of Veterans' Affairs services.

It is important to note that the incoming aged care reforms, including the new *Aged Care Act 2024*, will slightly shift the expenditure profile for government and consumers, placing greater emphasis on user-pays for non-clinical services. This is a positive shift.

4.3 Health and medical technology

Broadly, health and medical technology is funded through a range of sources including government funding, private investment, competitive grants, and consumer contributions. The Australian Government plays a critical role in funding these technologies through:[141]

- Services delivered via Medicare
- New medicines under the PBS
- Technologies delivered in the health and care system (such as hospitals)
- Research through a range of structures.

State and territory governments also fund these technologies via their public hospitals and health services, often, in partnership with the Australian Government.[142]

Private sector funding and investment, as well as philanthropic charities and foundations, also significantly support the development and commercialisation of these technologies.[143]

4.4 Health and medical research funding

Health and medical research is one of Australia's great strengths with significant discoveries which have gone on to save lives.[144] The development of the cervical cancer vaccine is just one an example. Cochlear hearing implants is another.

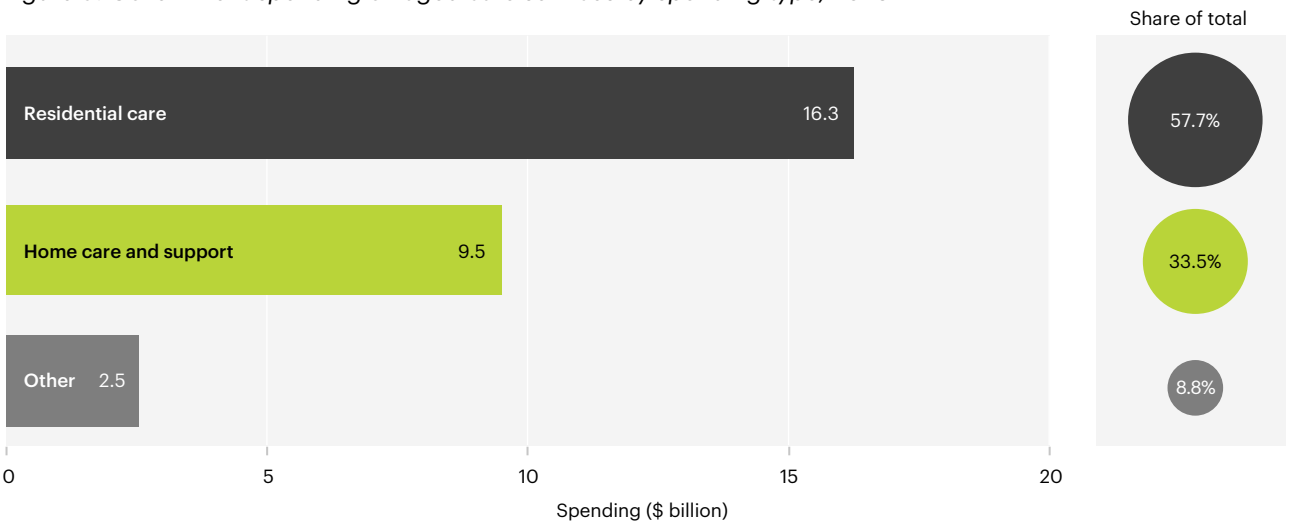
Research is funded through a range of sources, involving both the public and private sectors. The Australian Government is a primary funder, primarily through the NHMRC.[145] The NHMRC oversees the governance of research in Australia and is the leading government body funding research, including investigator-led research, clinical trials and public health studies.[146] In 2024-25, over $940 million was allocated to the Medical Research Endowment Account (MREA), with total funding projected to exceed $3.8 billion by 2027-28.[147]

The Australian Government also funds health and medical research through additional mechanisms, including:[148]

- The Medical Research Future Fund (MRFF) which supports strategic and translational research. From 2024-25, the government committed an additional $1.4 billion over 13 years, bringing the total investment to $6.4 billion.[149]
- The Australian Research Council
- The Cooperative Research Centres program
- Direct grants to universities
- The Research Block Grants
- Research & Development Tax Incentive
- The Biomedical Translation Fund (BTF)
- The National Reconstruction Fund (NRF)
- Other research organisations or health institutes.

During 2022-23, an estimated $7.4 billion was spent on health and medical research.[150]

Figure 9: Government spending on aged care services by spending type, 2023-24



Source: Commonwealth of Australia, Productivity Commission. (2025). *Report on Government Services 2025, Part F, Section 14.*

The Australian Government contributed $5.8 billion (78.4 per cent), state and territory governments contributed $1.1 billion (14.4 per cent) and the non-government sector contributed $0.5 billion (7.2 per cent).[151]

State governments are also significant funders of research and have been instrumental in establishing key precincts across Australia.[152] These include the Melbourne Biomedical Precinct in Parkville (including the Florey Institute of Neuroscience and Mental Health, the Walter and Eliza Hall Institute of Medical Research), the Westmead Health and Innovation District in Westmead, the South Australian Health and Medical Research Institute in Adelaide, the Herston Health Precinct in Herston Park (including the QIMR Berghofer Medical Research Institute), the Garvan Institute of Medical Research in Darlinghurst, and the Ramaciotti Centre for Genomics in Kensington.

The private and philanthropic sectors also actively support and fund research, exemplifying significant partnership such as Sanofi's $280 million investment in the Translational Science Hub in Brisbane.[153] How we continue to strategically drive research will be critical to achieving better health outcomes for Australians, and securing our future as a global health leader.

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05

Global perspectives

05

Global perspectives

Australia is currently positioned as a global leader in the latest world health rankings.[154] This is a significant achievement, and one many Australians may not fully appreciate. Despite this overall positive standing, various indicators reveal areas where Australia lags, highlighting the risk of complacency and the clear need for broader reform, if we are to maintain a healthy and productive population into the future.[155]

Leading the world

Australia's health system, underpinned by universal healthcare and a robust safety net for people as they age is a success.[156] International comparisons demonstrate that our unique mixed public and private system is relatively effective and efficient.[157] Government policies must actively reinforce and build upon this strength, rather than inadvertently undermine it.

We should cautiously avoid approaches seen in countries like the United Kingdom (UK), where the National Health Service (NHS) model is currently facing considerable challenges, with the UK Government itself acknowledging that 'the NHS is broken'.[158] Similarly, we should not emulate the United States (US) model, which expends a greater share of its GDP on healthcare without demonstrably better outcomes for all.[159]

Even as global health and care systems continue their recovery from the pandemic, there are several common challenges and opportunities that demand collective international effort. However, a one-size-fits-all approach may not always be appropriate with disparities in prevalent chronic conditions, such as obesity, which is more widespread in the Western world.[160]

Common global challenges include:[161]

- Workforce: Populations are ageing, bringing associated health challenges and revealing a limited mobile workforce to meet these escalating needs.
- Mental health: Mental health issues are increasing in both number and complexity.
- Antimicrobial resistance: The misuse and overuse of antimicrobials is leading to the development of drug-resistant pathogens, severely impacting our ability to effectively treat infections.
- Noncommunicable Diseases (chronic conditions): As people live longer, they are increasingly experiencing more serious chronic conditions, such as heart disease and diabetes.
- Infectious disease: People may be more frequently exposed to new infectious diseases due to global changes, including environmental shifts.
- Genomics: Genomics offers the unprecedented ability to understand an individual's unique genetic characteristics, providing potential pathways to prevent, diagnose and treat conditions with greater precision.
- Technological innovation: Rapid advancements in biomedical sciences, medical technologies and AI hold immense promise but also present potential risks, cost implications and access challenges.
- Climate change: Changes in climate, particularly extreme temperatures will impact people's health and the need for the system to respond. There is also the risk of changes in the spread of disease.

5.1 The Commonwealth Fund's *Mirror, Mirror* Report

In 2024, the Commonwealth Fund's highly reputable *Mirror, Mirror* report ranked Australia's healthcare system as the best of 10 countries (refer to Table 2).[162] In the eighth report comparing the performance of selected countries, Australia rose from third place to first, noting Norway opted out of the latest analysis. These findings are invaluable in helping governments learn from global experiences and understand how national policies affect health and wellbeing.[163]

Remarkably, Australia leads the rankings despite spending the least on health as a share of GDP (9.8 per cent), followed by the Netherlands (refer to figure 10).[164] In stark contrast, the US spends far more on health as a share of GDP (16.5 per cent) yet achieves poorer overall outcomes.[165]

Table 2: The Commonwealth Fund 2024 health system rankings

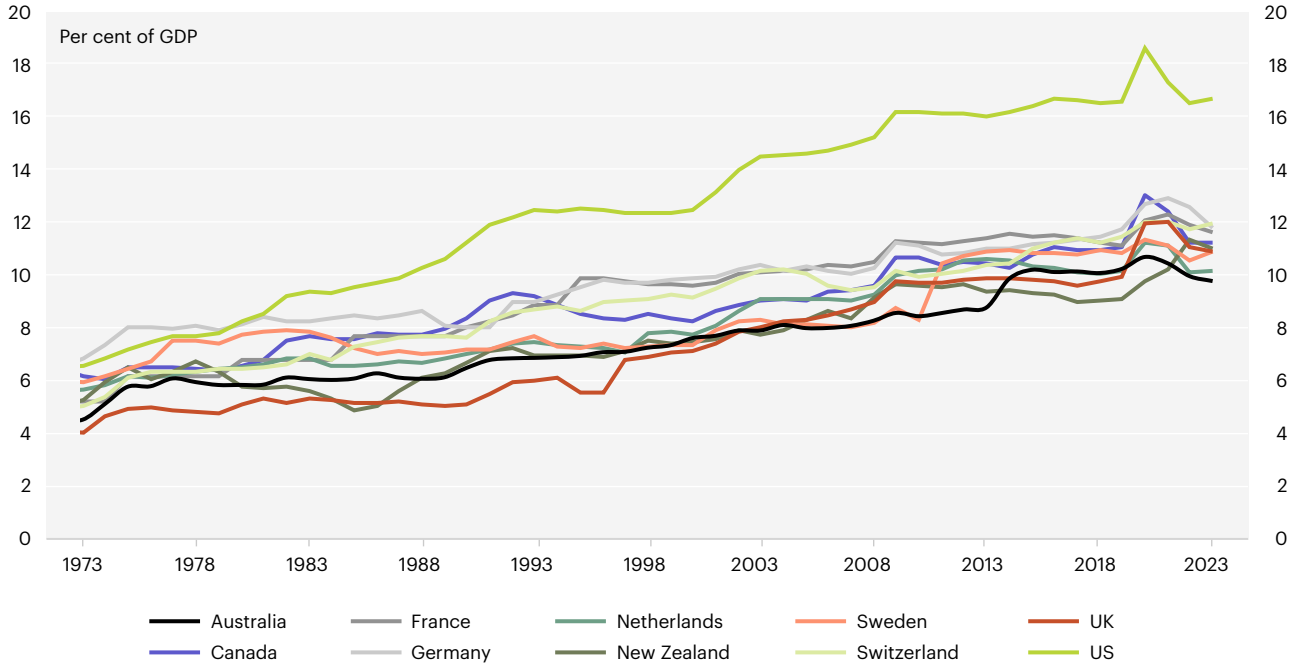
	AUS	CAN	FRA	GER	NETH	NZ	SWE	SWIZ	UK	US
Overall ranking	1	7	5	9	2	4	6	8	3	10
Access to care	9	7	6	3	1	5	4	8	2	10
Care process	5	4	7	9	3	1	10	6	8	2
Administrative efficiency	2	5	4	8	6	3	7	10	1	9
Equity	1	7	6	2	3	8	–	4	5	9
Health Outcomes	1	4	5	9	7	3	6	2	8	10

Source: Blumenthal, D et al. (2024). Mirror, Mirror 2024 A Portrait of the Failing U.S. Health System Comparing Performance in 10 Nations. *The Commonwealth Fund.*

This compelling evidence demonstrates that it is not necessarily the sheer amount of money spent that achieves the best outcomes, but rather how it is invested. Our system must continue to adjust in line with the evolving challenges our population faces; increased funding alone is not necessarily the solution.

While Australia ranks well on administrative efficiency, equity and health outcomes, there remains significant opportunities for improvements, particularly in access to care and care processes.[166]

Figure 10: The Commonwealth Fund healthcare spending as a percentage of GDP, 1980-2023



Data for Canada, Germany, Sweden, and the UK from 2023; data for Australia, France, Netherlands, New Zealand, Switzerland, and the US from 2022

Source: OECD Data Explorer, *Health Statistics.*

5.2 Organisation for Economic Co-operation (OECD) *Health at a Glance Report*

Australia ranks above average in most areas in the OECD *Health at a Glance 2023* report.[167] The report highlights that many health challenges can be tackled through preventative healthcare. Lifestyle factors such as smoking and alcohol contribute to numerous chronic conditions. Almost one-third of all deaths could have been avoided through more effective and timely prevention and interventions.[168]

5.2.1 Ageing population and carers: an OECD perspective

Only behind Japan, Australia boasts a high life expectancy at age 65, with people living an average of 21.7 more years beyond that age, compared with the OECD average of 19.5 years (refer to figure 11).[169] A total of 14.1 per cent of those aged 65 and over receive long-term care, a relatively high proportion compared to the OECD average of 11.5 per cent.[170]

With an ageing population, it is also notable that 19 per cent of Australians aged 50 and above are informal carers.[171] These carers play a crucial role in supporting the health and care system by reducing the need for government-funded services, helping people stay in their homes longer and taking pressure of an already limited workforce.

5.2.2 Digital health: an international view

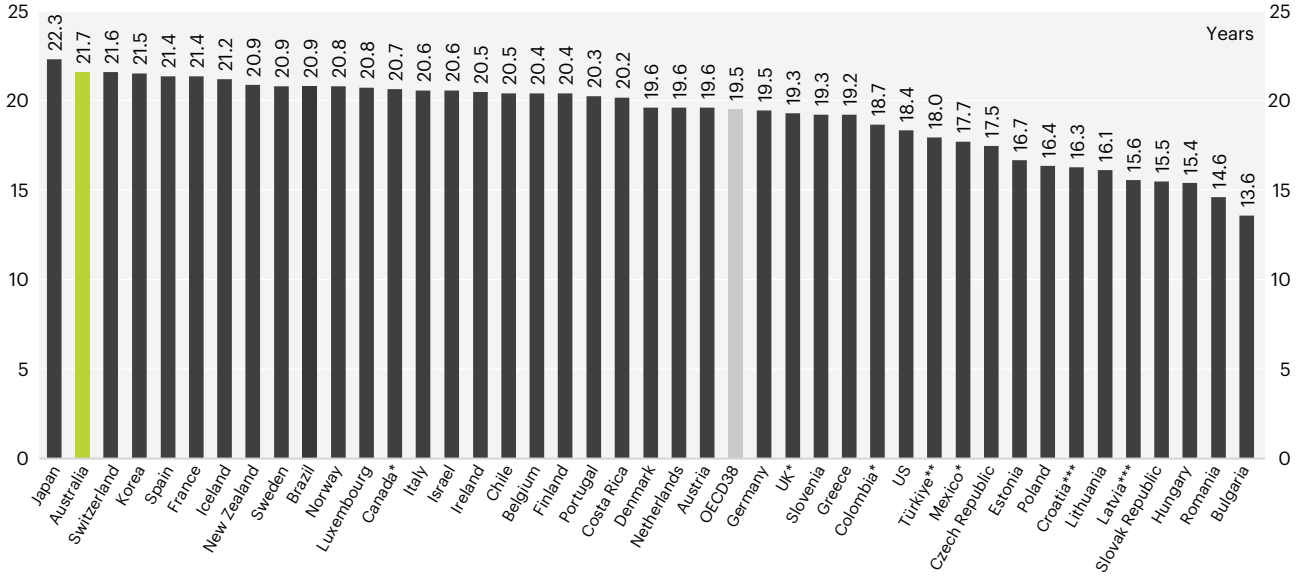
Achieving maximum value from digital health systems remains a global challenge because technologies and the underlying data environment are often outdated and fragmented.[172] Many barriers persist for countries aiming to achieve digital transformation, including:[173]

- A continued reliance on old technology such as fax machines, with 75 per cent of global fax traffic used for medical services.
- Multi-tiered and fragmented systems (public and private), leading to uncoordinated data use.
- Concerns about the administrative burden of digital health, often without yet fully realising the benefits from modern technologies.

Ninety per cent of OECD countries have an electronic health portal but only 42 per cent reported that the public could access and interact with all their data.[174] Alarmingly, 38 per cent had no clinical standards or vendor certification of electronic health records, significantly limiting data interoperability.[175] It is clear that the digital maturity and readiness of many countries differ, with further work required to recognise the benefits digital health solutions can bring to a system.[176]

Australia, for instance, is behind countries such as Denmark and France in dataset governance and the ability to access and link data effectively.[177] More concerted effort is needed to fully reap the transformative benefits of digital technology

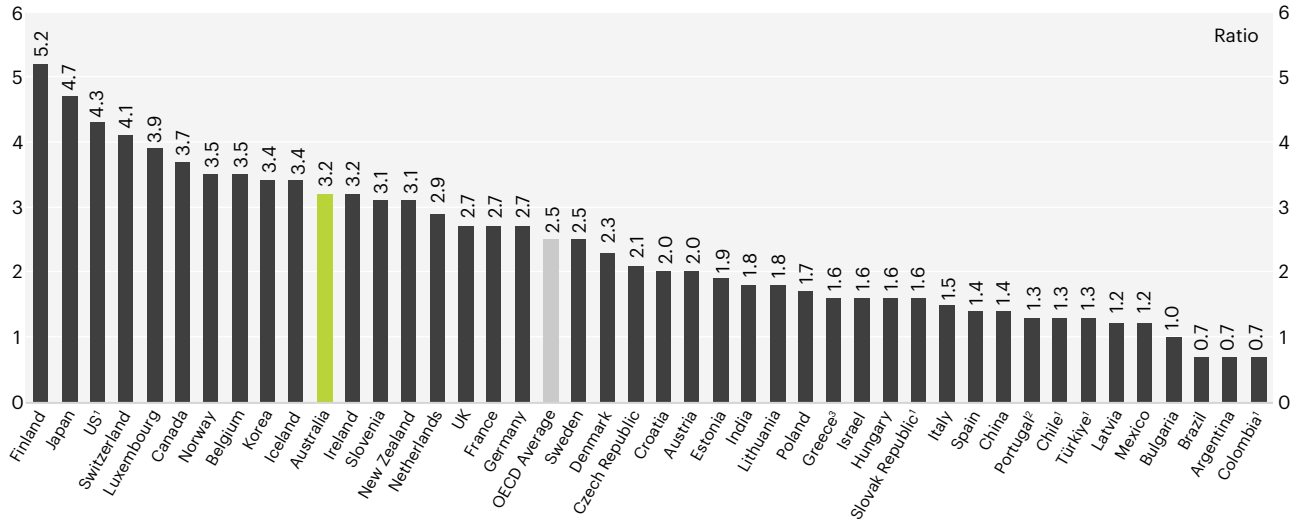
Figure 11: OECD life expectancy at age 65, 2021 (or nearest year)



Note: labels ending with * are 2020 figures, ** are 2019 figures. The latest data available for Croatia and Latvia is from the year 2001 and 2002 respectfully.

Source: European Union Eurostat Database and OECD Data Explorer, *Health Statistics*.

Figure 12: OECD ratio of nurses to doctors, 2021 (or nearest year)



1. Countries that use "professionally active" concept for doctors
2. Ratio underestimated (professionally active nurses/all doctors licensed to practice)
3. Data refers to nurses and doctors employed in hospitals

Source: OECD Data Explorer, *Health Statistics*.

across our health and care system. Increased use of anonymised data, with appropriate consumer consent, presents a major research opportunity that could fundamentally improve systems, deliver care where it is needed most and expedite the latest treatments.[178]

5.2.3 Workforce: a global challenge

The availability of health and care workers remains a pressing global challenge. To address this, most countries, including Australia, have adjusted and expanded scopes of practice and their reliance on both domestically and internationally trained workers.

Australia continues to perform above the OECD average for nurses, doctors and pharmacists, with numbers across these professions increasing.[179] We have the most number of nursing graduates with 115.7 per 100,000 people compared to the OECD average of 42.8.[180] Our medical graduate numbers, however, are much closer to the average, with 15.4 per 100,000 people compared to the OECD average of 14.2.[181] Australia has 3.2 nurses per doctor, which is above the OECD average of 2.5 but behind other countries such as Finland, Japan and the US (refer to figure 12).[182]

Given Australia has one of the world's highest shares of foreign-trained doctors and nurses, with 32.2 per cent and 18.1 per cent respectively compared to the OECD average of 18.9 and 8.7 per cent, the sustainability of that approach must be questioned, with a re-prioritisation to developing our domestic workforce for the future.[183]

5.2.4 Medical technology, including diagnostics

Medical technology and diagnostics play an important role in our health and care system but can be very costly.[184] Evidence suggests that too few machines may lead to access problems, while too many could result in overuse and unnecessary costs.[185] As an example, Australia ranks second in the OECD for the number of Computed Tomography, Position Emission Tomography and Medical Resonance Imaging units, trailing only behind Japan.[186]

Given the considerable cost of these machines and broader financial constraints, we need to carefully determine whether current equipment levels are appropriate, and whether access issues are primarily caused by distribution inequities between metropolitan and regional and remote areas.[187]

5.2.5 Clinical Indicators

The Australian healthcare system demonstrates both strengths but also areas of improvement compared to other OECD countries. For example, Australia performs relatively well in:[188]

- **Mortality following acute myocardial infarction (AMI):** Australia ranked fourth, behind Iceland, Norway and the Netherlands, with 3.3 per 100 separations for30 day mortality after hospital admission compared to the OECD average of 7.
- **Stroke mortality:** Australia ranked seventh, behind Switzerland, Israel and Canada, with 38 per 100,000 compared to the OECD average of 61.

However, Australia lags on some significant indicators which impact the health and productivity of our nation including:[189]

- **Ambulatory surgery:** Australia is the worst performer with post-operative pulmonary or deep vein thrombosis with 1,192 per 100,000 hip and knee hospital discharges compared to the OECD average of 467.
- **Pharmaceutical consumption:** Australia has a high rate of antidepressant use, with 128 defined daily doses per 1,000 people compared to the OECD average of 74.
- **Antibiotic use:** Australia has a high rate for the total volume of antibiotics prescribed, with 17 defined daily doses per 1,000 people compared to the OECD average of 13.
- **Avoidable hospital admissions:** Australia is also above the OECD average on many avoidable hospital admission indicators. By reducing the number of avoidable hospital admissions, Australia could reduce demand on its overstretched health system and limit the unnecessary additional financial burden.

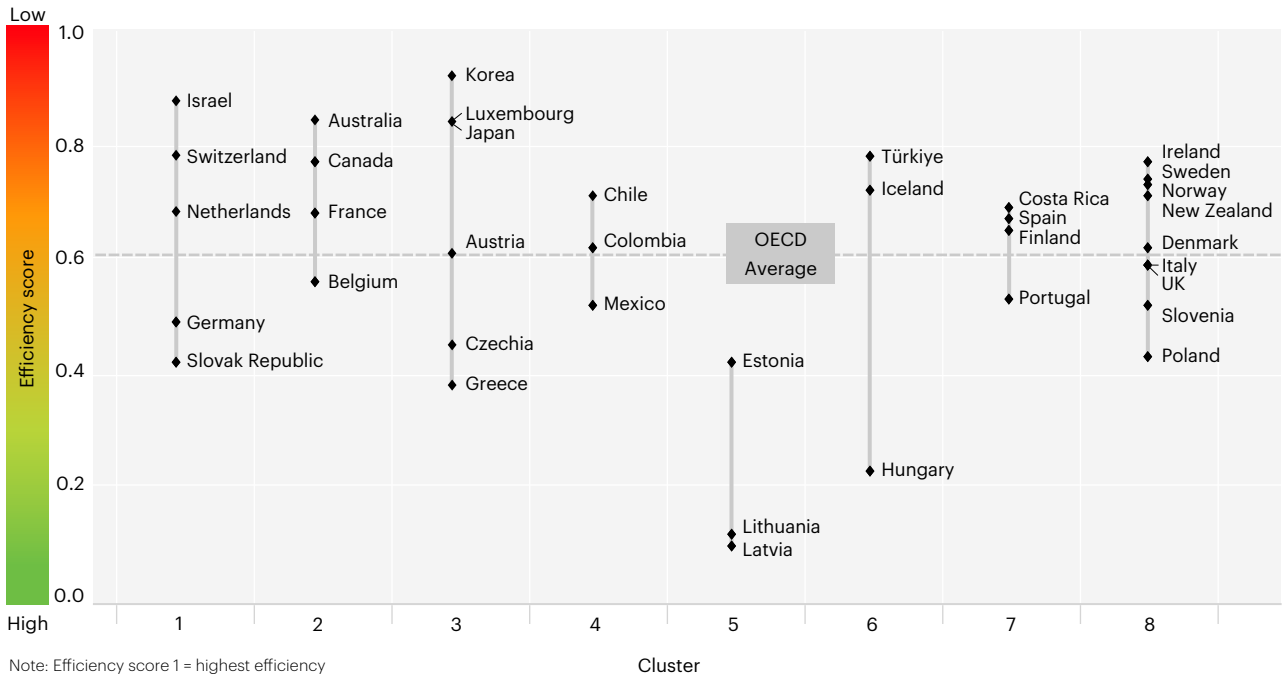
5.3 OECD: *How do health system features influence health system performance?*

The OECD and the Health Foundation research paper *How do health system features influence health system performance?* identified groups of countries with similar health system characteristics and compared and assessed their performance.[190] The paper suggests countries should focus on implementing specific policy improvements that can enhance performance, rather than whole system change by adopting best practice with similar systems.[191] Clustering is a technique which can be used to form groups of similar health systems that share distinct properties.[192]

Key findings include:

- **No one "best" health system exists or consistently outperforms others:**[193] Of the eight clusters for this metric, health systems can achieve similar levels of efficiency even with different sets of characteristics. Overall, Australia ranked fifth, behind Korea, Israel, Luxembourg and Japan (refer to figure 13).

Figure 13: Efficiency scores within and across health system clusters, 2019



Note: Efficiency score 1 = highest efficiency

Source: OECD/The Health Foundation (2025), *How do health system features influence health system performance?*

- **Strong financial incentives for providers to deliver quality services showed lower treatable mortality rates compared to limited incentives for quality:**[194] This difference was particularly significant in systems that combined weak quality incentives with fee-for-service payment methods. Of the three clusters for this metric, cluster 3 showed a statistically significant potential to improve outcomes.
- **Strong gatekeeping, high continuity of care and substantial financial incentives for quality demonstrated lower rates of avoidable hospital admissions systems compared to other systems:**[195] Accounting for the study limitations, higher avoidable admission rates were reported in countries with higher inequality in income distribution, higher level of education attainment, and higher number of hospital beds. Of the five clusters for this metric, cluster 1 presented statistically significant lower avoidable admission rates relative to other clusters.

5.4 Flinders University (aged care)

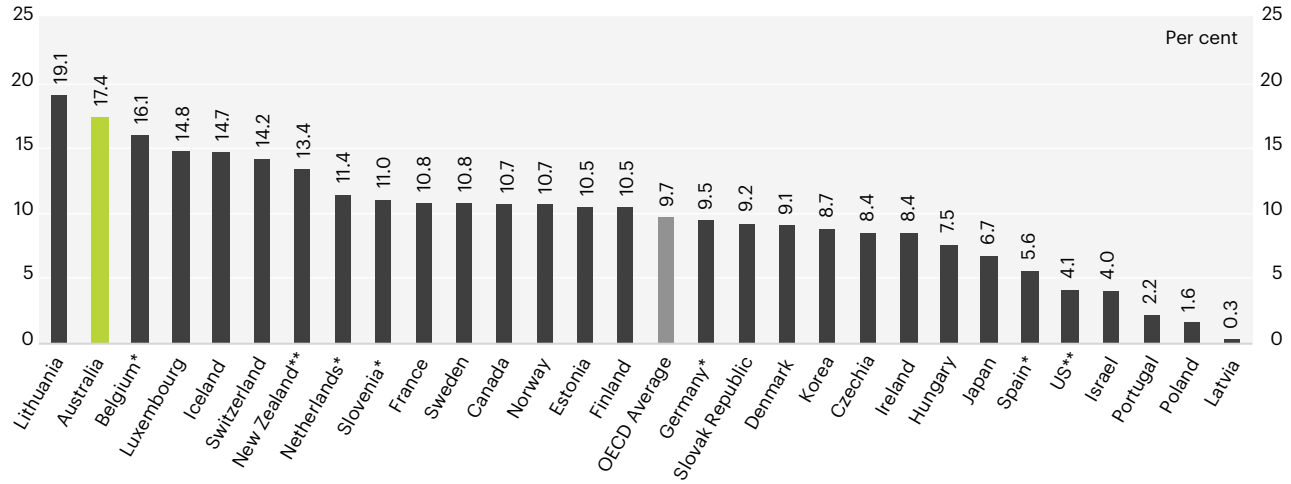
A significant review was undertaken by Flinders University for the *Royal Commission into Aged Care Quality and Safety* into the long-term care models for older people in various countries, contextualising Australia's approach.[196] It is important to acknowledge that this comprehensive report reflects Australia's aged-care landscape prior to the significant reforms initiated following the Royal Commission.

The Flinders University report highlighted the inherent challenges in making international comparisons regarding the quality of integration between long-term care systems and broader health systems.[197] However, it did suggest that Australia's quality of integration and coordination of care between health and social care systems may not have been as comprehensively developed in other leading nations.[198]

Globally, countries like Denmark and Sweden are recognised for their high-quality long-term care systems.[199] While Australia demonstrated commendable access to aged care services and a highly regulated environment, at times, this was at the expense of flexible financing arrangements and a reliance on individual consumer spending.[200] At the time of the report, Australia's expenditure on long-term care was estimated to be 1.2 per cent of GDP, below the OECD average of 2.5 per cent.[201]

Furthermore, the review revealed key areas for national focus. Australia historically has a higher proportion of people aged over 80 receiving long-term residential care compared to other nations (refer to figure 14), alongside a substantial number of informal carers compared to other OECD countries.[202] This approach to care is being increasingly challenged, with reforms being implemented to support increased care in the home.

Figure 14: Percentage of population aged 80 and over living in institutions, 2022 (or nearest year)



* 2021 figures ** 2020 figures

Source: OECD Data Explorer, *Health Statistics*.

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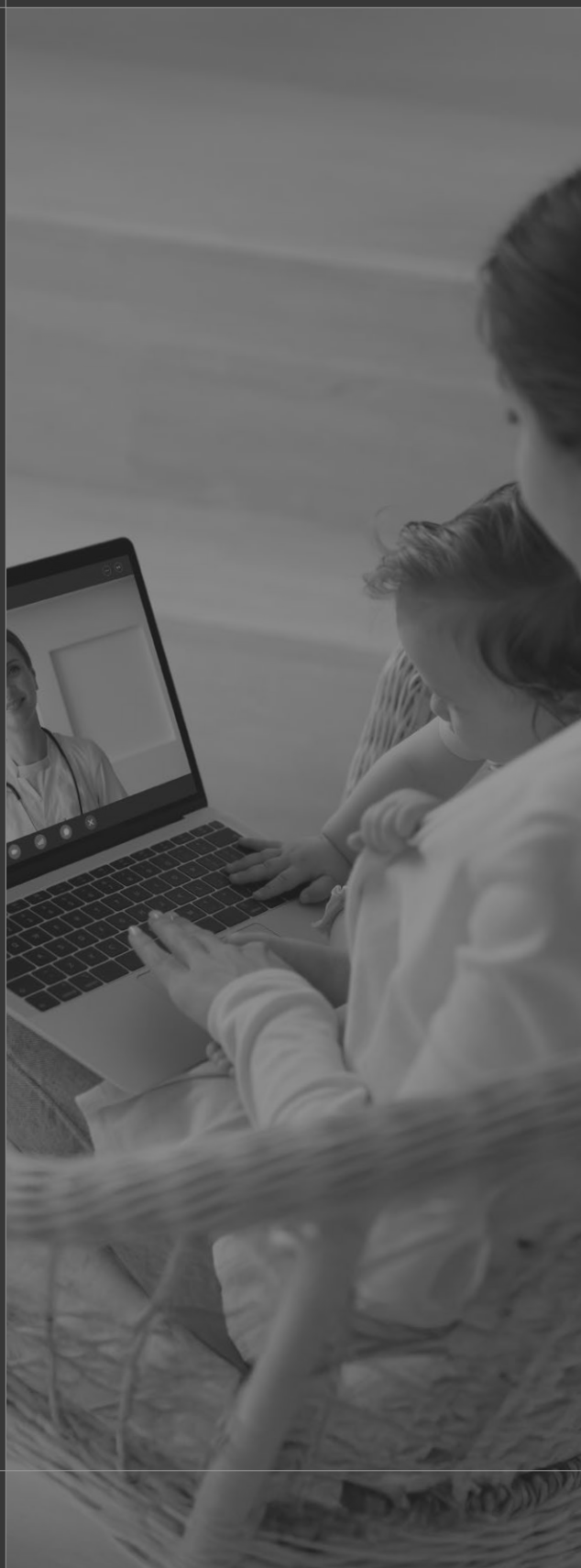
06

Australia's health and care challenges

06

Australia's health and care challenges

Australia faces many challenges common to other countries, alongside some unique issues stemming from our geographic location and size.[203]



Domestic perspectives

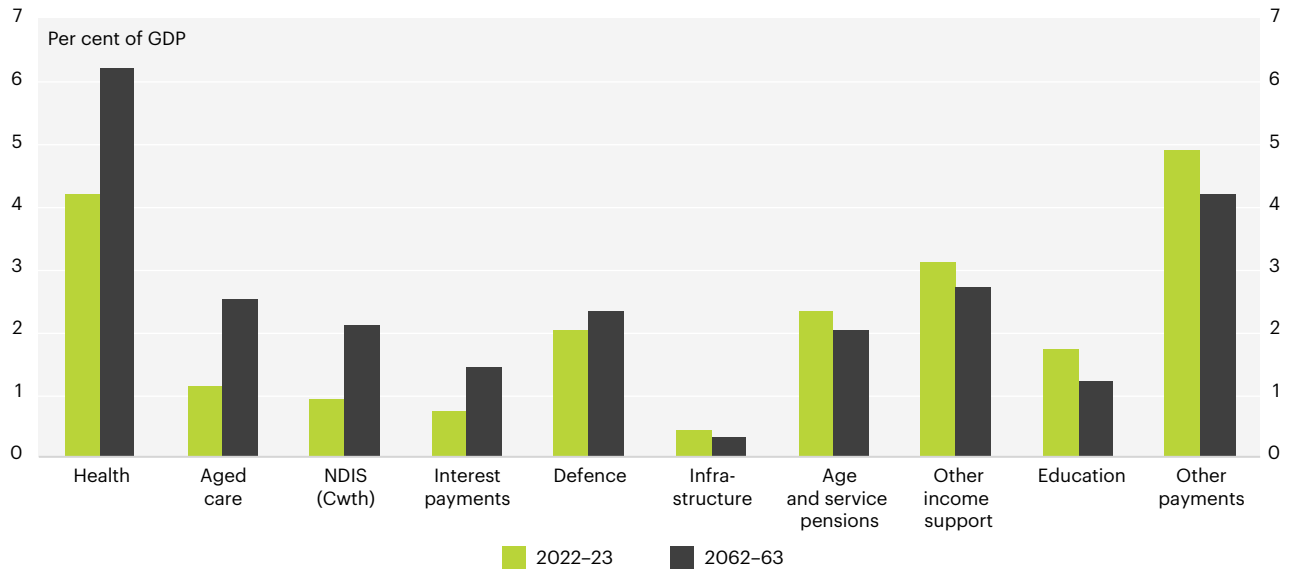
There has been no shortage of policy reports outlining these challenges which include:[204]

- Noncommunicable diseases (chronic conditions): Over 90 per cent of Australia's non-fatal burden of disease is related to chronic disease.
- Ageing population: An ageing population continues to place significant pressure on the health and care system to meet the needs of an older demographic.
- Mental health: Australians continue to experience many mental health challenges, a situation that is not improving and is further exacerbated by longer wait times to access support.
- Workforce: Limited workforce availability, due to a decreasing birth rate and an ageing population, impacts the ability to meet the health and care needs of the population.
- Access to care: Many Australians cannot access services they require due to rising out-of-pocket costs and longer wait times.
- Inequities: Despite performing relatively well internationally, Australia lags in addressing health inequities and disparities with specific populations, including First Nations people and reaching communities in rural and remote areas.

6.1 Australian Treasury *Intergenerational Report 2023*

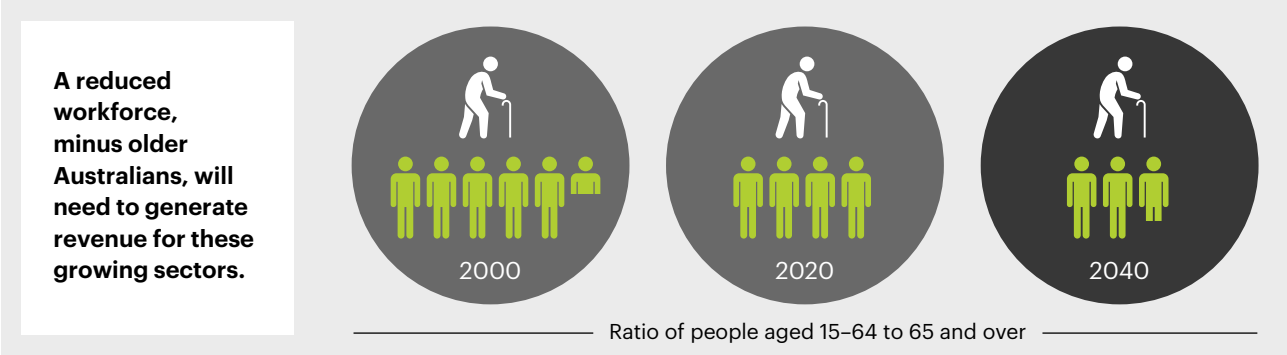
Australia's health and aged care systems are currently unprepared for the anticipated substantial growth in patients and aged care residents, alongside a projected reduction in economic participation. The Intergenerational Report has consistently highlighted this risk since its inception. The *Intergenerational Report 2023* (IGR) specifically details how Australia's economy is expected to evolve in the coming decades, with a particular focus on population changes, emerging technologies, and the increasing demand for health and care services.[205]

Figure 15: Government expenditure as a share of GDP, 2022-23 and 2062-63



Source: Commonwealth of Australia (2023). *Intergenerational Report 2023 Australia's future to 2063.*

Figure 16: Number of working Australians per retiree



Source: Commonwealth of Australia (2023). *Intergenerational Report 2023 Australia's future to 2063.*

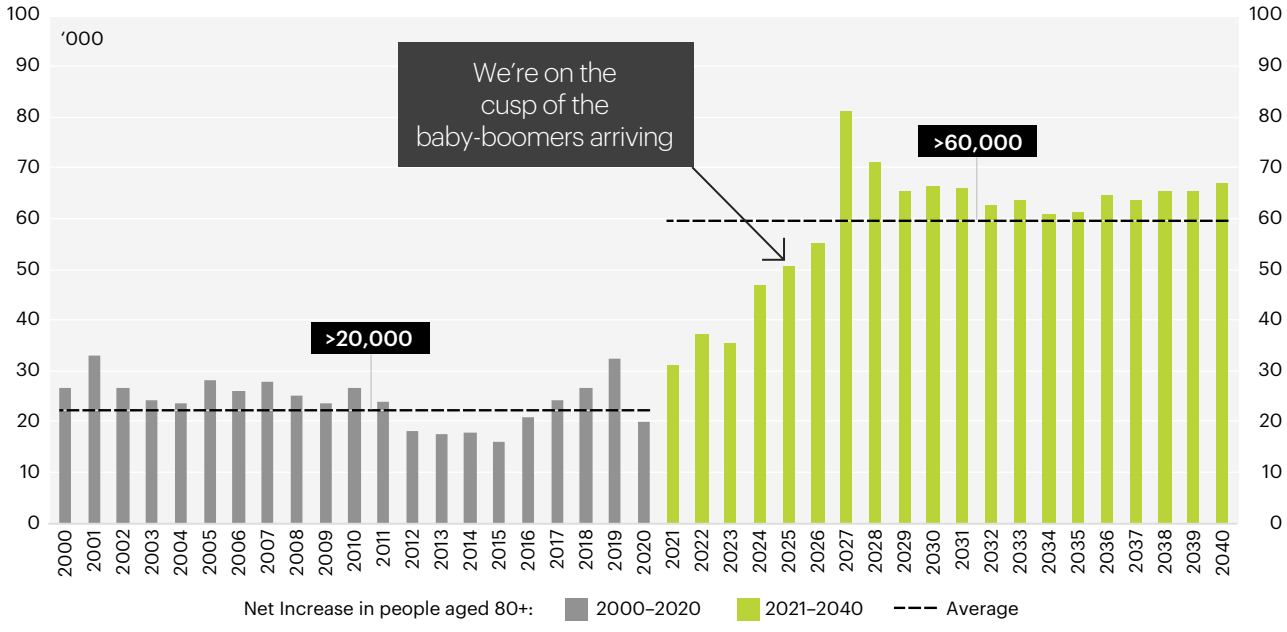
The most significant areas of government expenditure – health, aged care, the NDIS, defence, and interest on government debt – are collectively projected to grow from 8.8 per cent of the economy to approximately 14.4 per cent by 2062-63 (refer to figure 15).[206] Within this, health and care spending alone is expected to exceed 10 per cent of GDP.[207]

Hospital expenditure, the fastest-growing component of health expenditure, is projected to rise from $950 per capita in 2022-23 to $1,300 per capita in 2033-34 – a substantial increase of 35 per cent in real terms.[208] In aged care, residential care will be the primary driver of increased expenditure, with a growing and ageing population expected to account for 70 per cent of the projected real increase in aged care spending per person.[209]

Australian Government spending is projected to significantly outpace revenue growth, with the number of working Australians per retiree expected to fall from approximately four to less than three within 40 years (refer to figure 16).[210] This means there will be fewer people working to fund an increasing demand for care.

A significant challenge we face, particularly from 2027 onwards, is the growing ageing population. Those aged 65 and older are projected to increase by 6.1 per cent to 23.4 per cent of the population by 2062-63.[211] Australians aged over 80 are the primary users of aged care services, and their numbers are expected to triple to more than 3.5 million people by 2062-63 (refer to figure 17).[212] This projected figure is equivalent to the current combined population of Western Australia and the Australian Capital Territory.[213]

Figure 17: Population aged 80+ will surge



Source: Australian Bureau of Statistics. (2024). *National, state and territory populations.*

An ageing population is also expected to account for 40 per cent of the projected increase in health spending, with non-demographic factors such as the funding of new technology, making up the remaining 60 per cent.[214] Additional factors that could influence future government spending and service provision include:[215]

- Changes in the average cost of providing care, such as price or wage changes.
- The incidence of frailty, disease and disability within the population leading to an increase in the use of services.
- Changes in government policy, including the level and composition of subsidised services, such as medicines on the PBS and new technologies.
- Regulatory settings and the distribution of costs across governments and households.
- Changing preferences of older Australians, particularly the increasing desire for ageing in the home rather than in residential care.

While this paper does not specifically address the NDIS, it is important to note the IGR's identification of the scheme as an area of cost pressure in the broader health and care system.[216] The BCA acknowledges the Australian Government's efforts to moderate NDIS growth, with early indications suggesting that reforms are yielding positive results.

We recognise the Australian Government's recent announcement to reform service provision for children with mild to medium autism. The impact on the broader health system must also be carefully considered to avoid shifting pressures to other areas and impacting other consumers.

We agree that a long-term, viable solution is essential to continue delivering life-changing outcomes for people with disability.[217] This requires examining not only the design, operation and sustainability of the NDIS itself, but also how it intersects with the wider health and care system, encompassing primary care, tertiary care and aged care. Such an assessment will identify potential duplication and redundancies, improve overall system efficiencies, and clarify which services the NDIS should appropriately cover.

The IGR concludes that:

'...This requires a health system that innovates and prioritises funding a patient-centred and sustainable Australian healthcare system that delivers the best outcomes for communities. This will require funding arrangements that continue to effectively invest in preventive health and evidence-based healthcare spending.' [218]

6.2 Tax and Transfer Policy Institute

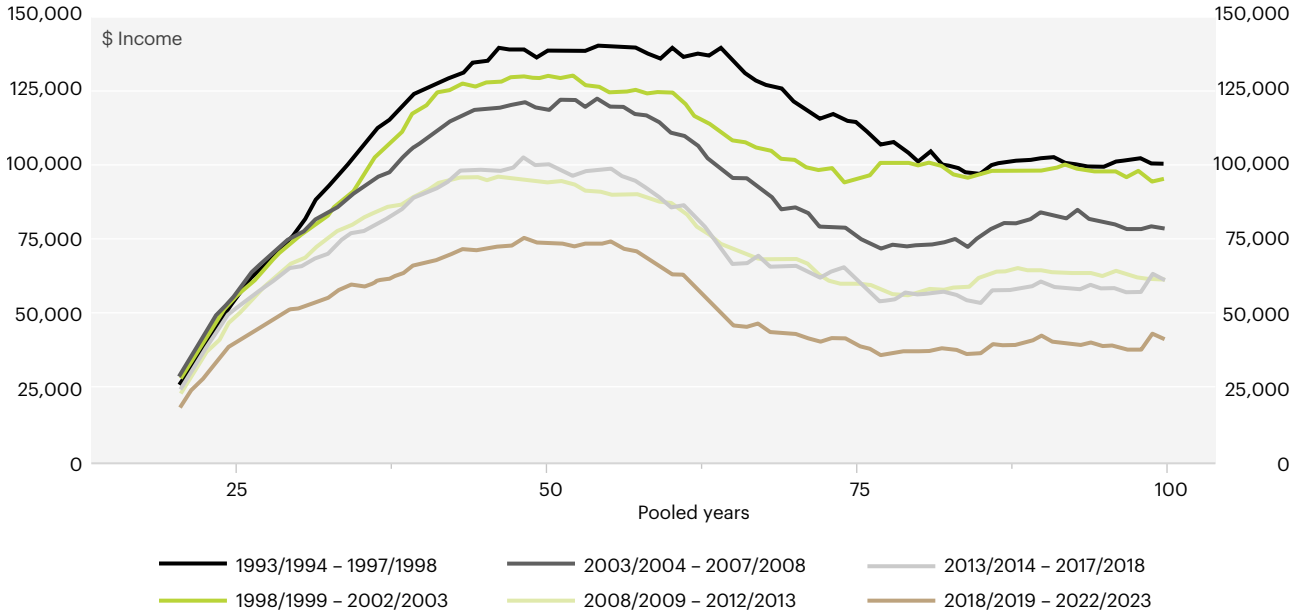
The Tax and Transfer Policy Institute highlights the additional financial pressures on younger Australians identified by the IGR.[219] It also shows that the government is spending significantly more on providing health and care services for older Australians, when measured in real, per person terms.[220] This situation is not merely a consequence of an ageing population, rather, it reflects the 'net mean impact of the Australian tax and transfer system on individuals of different ages' (refer to figure 18).[221] The system has, in recent decades, become more generous towards older Australians.[222]

Consequently, despite comparable pre-tax incomes, the average post-tax/transfer income of older Australians is now considerably higher than that of younger Australians.[223] Averaged over the past 10 years, Australians aged over 65 had an average final income (after taxes and transfer payments) of $72,000, whereas those aged 18-30 had an average final income of $64,000.[224]

For our system to remain sustainable, we must consider whether those who can afford to pay more, should contribute more for their care. Older Australians will inevitably place greater demand on funding for health and aged care services.

Any tax reform must be undertaken from a holistic perspective. The recent Economic Reform Roundtable reflected an encouraging appetite to continue to discuss broader tax reform and long-term economic competitiveness, based on three objectives: addressing intergenerational equity, affordably incentivising business investment, and making the tax system simpler and more sustainable.

Figure 18: Average real income per person after taxes and transfers



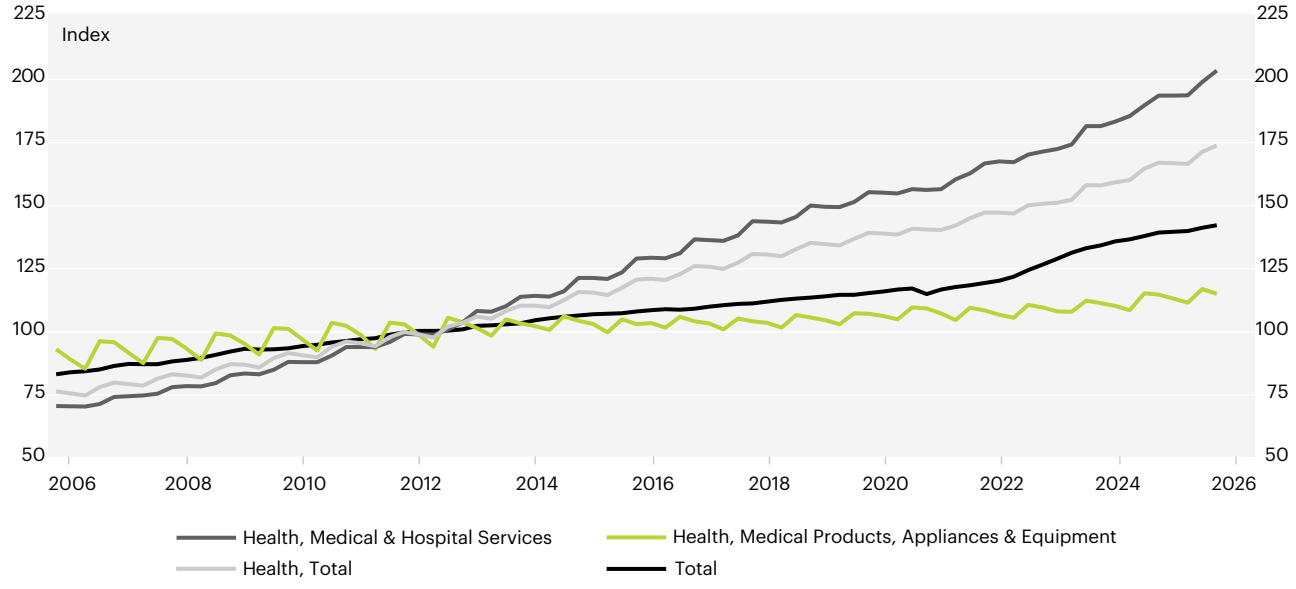
Source: Varela, P., Breunig, R., and Smith, M. (2025). 'Measuring the changing size of intergenerational transfers in the Australian tax and transfer system'. Australian National University Crawford School of Public Policy, Tax and Transfer Policy Institute, Working Paper 7/2025, May 2025.

6.3 Productivity, inflation and the health and care economy

The Australian health and care sector is a major part of the national economy, and its sustainability is directly linked to productivity. Prices for health and hospital services have risen faster than Australia's overall Consumer Price Index (CPI), and compared to medical products and equipment (refer to figure 19).[225]

Productivity can be measured in different ways. The growth of the workforce has had an impact on national productivity rates. Since 2020, the health and care sector's lower productivity growth rate has reduced measured labour productivity growth by an average of 0.2 percentage points each year.[226] Improving productivity in the sector is a key opportunity for the Australian economy.

Figure 19: Health CPI sub-indexes compared to overall CPI



Source: Australian Bureau of Statistics. *Consumer Price Index, Australia.*

6.4 e61 Institute

Analysis from the e61 Institute highlights the significant expansion of the health and care economy, which now employs around 15 per cent of Australians, up from 10 per cent a decade ago.[227] This includes the medical, aged, child and disability sectors, with the latter showing particularly strong job growth.[228]

6.4.1 Jobs and wages growth

Recent studies show the health and care economy is the fastest-growing sector, attracting workers from other industries and creating more job vacancies than any other.[229] Relatively high wage growth in this sector is encouraging labour reallocation, and this has an impact on broader national productivity.[230] The only industry with higher wage growth was utilities and energy.[231] Furthermore, government-supported wage increases for early childhood and aged care workers will lead to a future rise in pay, against a backdrop of relatively high consumer price inflation.[232]

6.4.2 Carers

Unpaid carers also play a crucial role. About one in 10 working-age Australians provide unpaid care, but as the age of these carers increases, so does the potential for a greater reliance on the formal care system.[233] This has financial implications, as data shows carers are less likely to return to the paid workforce, which negatively affects both their personal finances and the wider economy.[234]

6.5 Insights from the Productivity Commission

The Productivity Commission (PC) has undertaken extensive research on the health and care economy, including the recent interim report into *Delivering quality care more efficiently*. While productivity growth in the health and care sector is challenging to achieve at the same rate as other industries, there are notable successes and opportunities for improvement.

6.5.1 Delivering quality care more efficiently

The PC has been asked by the Australian Government to conduct an inquiry into *Delivering quality care more efficiently* as part of the government's five pillars of productivity inquiries.[235]

The interim report presents draft recommendations on three key policy reform areas:

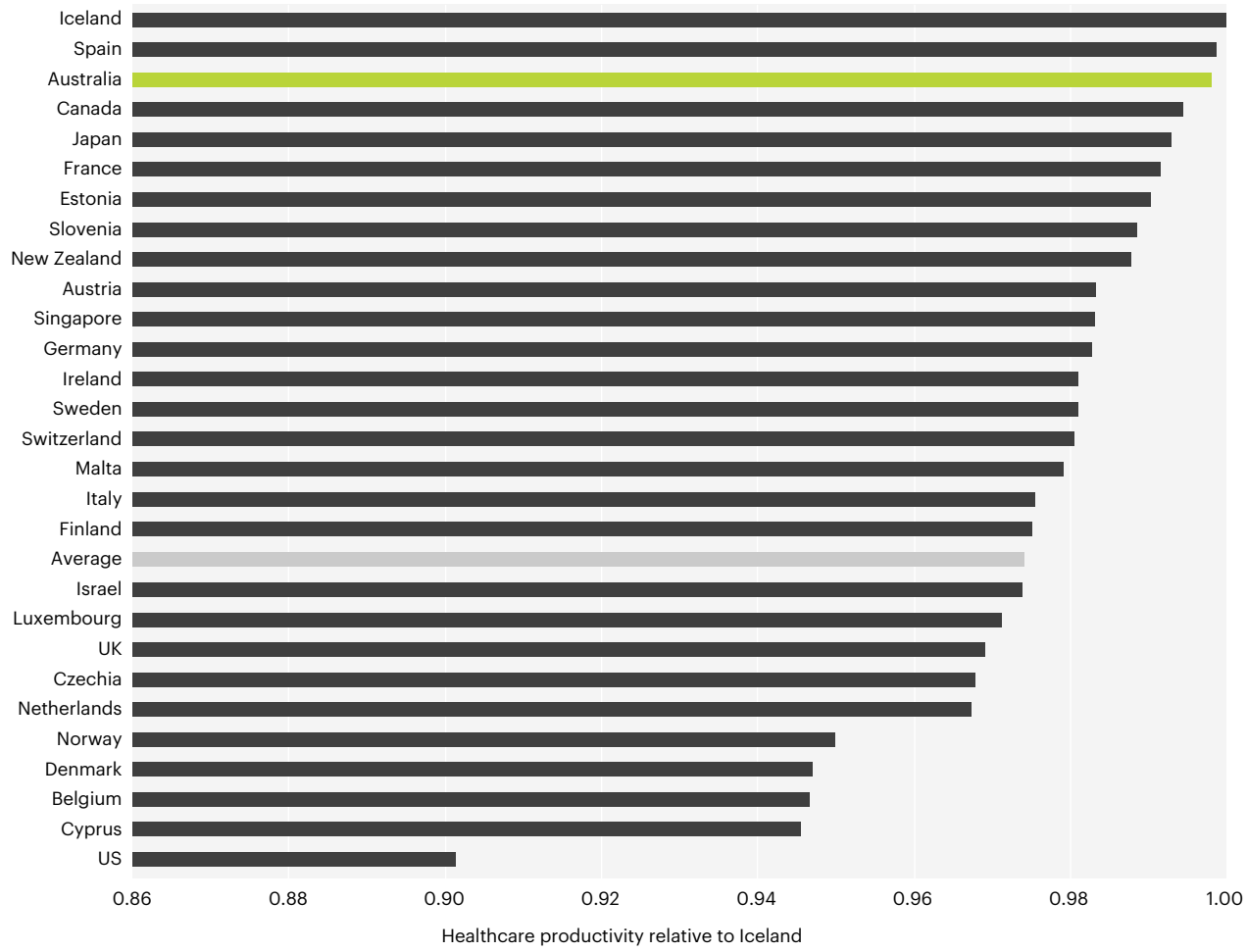
- Reform of quality and safety regulations to support a more cohesive care economy:[236] Greater alignment in quality and safety regulation of the care economy to improve efficiency and outcomes, with an initial focus on aged care, NDIS and veterans. This also includes aligning care worker regulation (such as worker screening and registration), provider accreditation, registration and audits as well as broader regulation (such as AI).
- Embed collaborative commissioning to increase the integration of care services:[237] Embed collaborative commissioning, with an initial focus on reducing fragmentation in healthcare to foster innovation, improve care outcomes and generate savings. This includes new governance and funding arrangements.
- A national framework to support government investment in prevention:[238] Establish a National Prevention Investment Framework to support investment in prevention, improving outcomes and slowing the escalating growth in government care expenditure. This includes establishing an Independent Prevention Framework Advisory Board, specific funding and an intergovernmental agreement.

6.5.2 Advances in measuring healthcare productivity

The PC's research paper, *Advances in Measuring Healthcare Productivity*, found that Australia's healthcare spending is justified and delivers value.[239] The paper evaluated productivity growth in one-third of the nation's healthcare sector by factoring in both the quality of care and the impact of substitutions, such as shifting to more efficient treatments or services.[240] Key findings include:

- Spending on healthcare is worth it:[241] Productivity has grown by 3 per cent a year (quality adjusted) between 2011-12 and 2017-18 in the treatment of five specific diseases. This means health outcomes from these treatments have improved more than the money spent. By comparison, the overall market sector grew by only 0.8 per cent a year over the same period. This growth can be attributed to quality improvements and the diffusion of new treatments, rather than broad health reforms or doing more with less.[242]

Figure 20: Average estimated relative healthcare productivity level by country, 2010 to 2019



Source: Commonwealth of Australia, Productivity Commission. (2024). *Advances in measuring healthcare productivity research paper.*

- Australia offers good value for its healthcare dollar:[243] Australia spends about one in every ten dollars on healthcare and ranks third in productivity among 28 high-income countries when accounting for age, behavioural and environmental risk factors (refer to figure 20). However, the nation faces challenges, including the fourth-highest obesity rate, the sixth-highest level of alcohol consumption, and relatively low consumption of fruit and vegetables.
- Good performance is not grounds for complacency:[244] Despite Australia's strong and growing value for its healthcare spending, an ageing population, rising societal expectations, and increasing disease rates highlight the need for further reform.

6.5.3 Leveraging digital technology in healthcare

The PC's research paper *Leveraging digital technology in healthcare*, considered how digital technology can improve patient outcomes and enhance productivity, enabling governments to reduce costs and ease pressure on the system.[245] Digital technology is a vital enabler of productivity growth.[246] Key findings include:

- Integrating digital technology could save money:[247] Better integration of digital technology could save up to $5.4 billion per year in hospital costs. This could be achieved by making better use of data in electronic medical record systems, reducing the length of time patients spend in hospital, and saving up to $355 million through fewer duplicated tests.

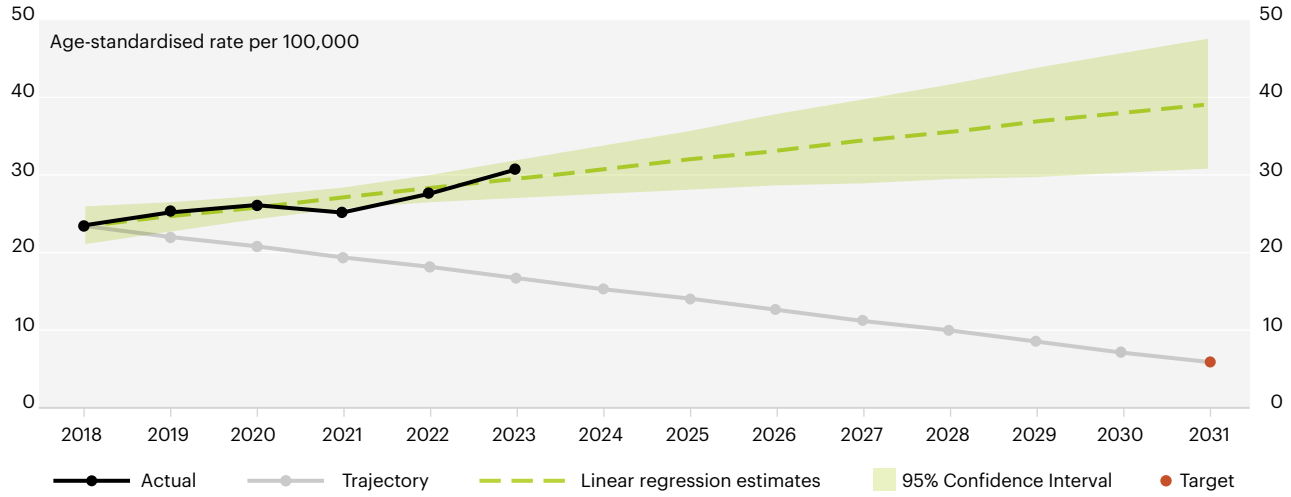
- Unlocking new opportunities:[248] While the use of telehealth has increased, remote monitoring and digital therapeutics continue to lag. The full potential of AI in guiding decision-making and automating tasks has not yet been realised. Regulatory settings must be appropriate to attract investment and help all stakeholders coordinate to deliver cost-effective alternatives to traditional services.
- Innovation offers a better consumer experience:[249] Consumers can access care from home through digital innovations such as telehealth, digital therapeutics and remote monitoring. Nearly one in five Medicare-funded GP consultations and one in 10 specialist consultations now occur via phone or video. Telehealth delivers consumer gains of around $895 million per year in reduced travel time.
- Improving information sharing is crucial:[250] Non-interoperable systems make information sharing difficult. Changes to standards and functionality are needed for better information sharing, including incentive-based initiatives. All levels of government should better coordinate to deliver interoperable systems that provide value for money and deliver on interoperability objectives.
- Greater uptake of remote care is needed:[251] Remote care and digital therapeutics can address challenges, such as workforce shortages and a lack of access due to distance, particularly in regional, rural and remote areas, while also offering convenience, lifting productivity and reducing costs. These services are not yet embedded in standard models of care due to a lack of guidance from government or clinical bodies and gaps in funding. Greater coordination is needed to close coverage gaps and prevent duplication of services. Targeted government funding and a central portal of approved services could support this.
- Harnessing AI requires greater trust and improving data access:[252] AI has significant potential to boost productivity by streamlining decision-making and improving efficiency, and could free up as much as 30 per cent of a clinician's time. However, trust and risk are key issues. Regulatory approval processes must keep pace with advancements while maintaining adequate oversight and privacy protections.

6.5.4 Mental health

The PC's *Mental Health* report discusses the key influences on people's mental health, its effects on their ability to participate and prosper, and its broader implications for the economy and productivity.[253] Key findings extend across the workplace, schools, universities, community and health, including:

- Australia's mental health system would benefit from reform:[254] Almost one in five Australians has experienced mental illness in a given year, with many not receiving the treatment and support they need. Reforms of the mental health system would produce large benefits valued at up to $18 billion annually. There would be an additional annual benefit of up to $1.3 billion due to increased economic participation. About 94 per cent of the benefits (~$17 billion) could be achieved by adopting identified priority reforms, requiring expenditure of up to $2.4 billion per year and generating savings of up to $1.2 billion per year.
- Creating a person-centred mental health system requires reforms that:[255]
  - Focus on prevention and early intervention:[256] The mental health of children and families should be a priority, with prevention and early intervention continuing through tertiary education and employment.
  - Provide the right healthcare at the right time:[257] People should have real choices in managing their own mental health and be empowered. Technology should play a larger role by improving assessment and referrals, and access to services. The cycle of people in and out of hospital should be addressed to reduce personal and taxpayer costs.
  - Ensure effective services support recovery in community:[258] Community treatments and supports should be expanded for people who do not require hospital care but need more support than a GP can provide. Housing, employment services and other supports that help individuals integrate back into the community are important.
  - Provide seamless care regardless of funding sources:[259] The 'back office' of the mental healthcare system needs to be redesigned with planning to meet local needs. Providers and governments should be held to account through transparent monitoring, reporting and evaluation of what works.

Figure 21: Age-standardised suicide rate per 100,000 Aboriginal and Torres Strait Islander people, 2018 to 2023



Source: Commonwealth of Australia, Productivity Commission. (2025). *Closing the Gap Annual Data Compilation Report*.

6.5.5 Closing the Gap

The PC's *Closing the Gap Annual Data Compilation Report 2025* provides insights into progress against the national targets in the *National Agreement on Closing the Gap*.[260] Overall, there has been mixed progress in the 19 socio-economic outcomes. Improvements have been made in the following outcomes, but they are still not on track to be met by 2031:[261]

- Born healthy and strong:[262] A higher proportion of Aboriginal and Torres Strait Islander babies are being born at a healthy weight (89.2 per cent in 2022, target 91 per cent). This is down from 89.6 per cent in 2021, but up from 88.6 per cent in 2017. Positively, smoking rates during pregnancy fell and early prenatal care rates have risen.
- Long and healthy lives:[263] The life expectancy gap between Aboriginal and Torres Strait Islander people and non-Indigenous people is improving, with a life expectancy of 75.6 and 71.9 years for females and males born in 2020-22, respectively (target is a gap of zero). However, mortality rates for most age cohorts and avoidable mortality are increasing.

Concerningly, a crucial outcome is worsening, and the target of a significant and sustained reduction is not on track to be met:[264]

- Social and emotional wellbeing:[265] The rate of deaths by suicide for Aboriginal and Torres Strait Islander people is increasing, with 30.8 per 100,000 people taking their own life in 2023 (refer to figure 21). In 2023, rates were nearly threes time higher for males than female (48.5 to 13.8). Psychological distress also remains with about one in three people experiencing high or very high levels of distress.

6.6 Australian Institute of Health and Welfare

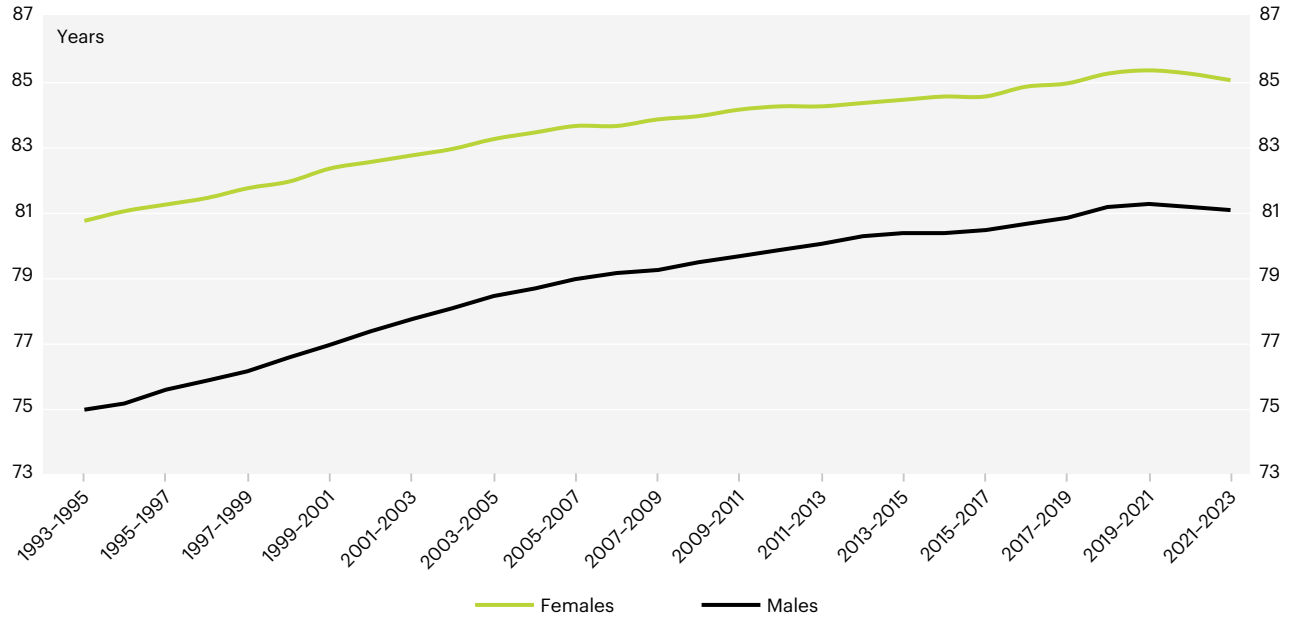
The Australian Institute of Health and Welfare (AIHW) produces authoritative and accessible information and statistics to inform and support better policy and service delivery decisions, ultimately leading to improved health and wellbeing for all Australians.[266]

6.6.1 Life expectancy

Australians' life expectancy has improved, largely due to medical and technological advancements.[267] We rank seventh out of 38 OECD nations, with a life expectancy of 83.2 years for men and women in 2023, down from fourth in 2022, at 83.3 years (refer to figure 22).[268] This means we are still living about 30 years longer than we did between 1891 and 1900.[269]

Discrepancy persists between the life expectancy of First Nations people and non-Indigenous Australians. This represents a gap of nearly 8 to 9 years, a difference that, as an advanced economy, we must work harder to address.[270]

Figure 22: Life expectancy at birth



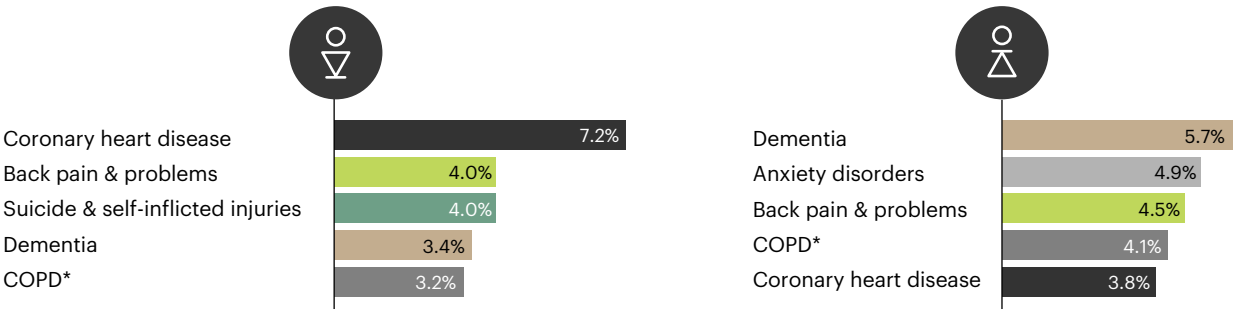
Source: Commonwealth of Australia, Australian Bureau of Statistics. (2024). *Life expectancy 2021-2023.*

6.6.2 Health-adjusted life expectancy

With the increasing burden of disease, it is important to focus on health-adjusted life expectancy (HALE).[271] This measure reflects the goal of not just living longer but also maximising the years spent in good health.

In 2024, men and women could live an average of 88 per cent and 86 per cent of their lives in full health.[272] This equates to 71.7 years out of 81.6 years for male life expectancy and 73.8 years out of 85.5 years for female life expectancy.[273] Despite overall improvements in life expectancy, increased ill health across the population is placing a greater demand on the health and care system.[274]

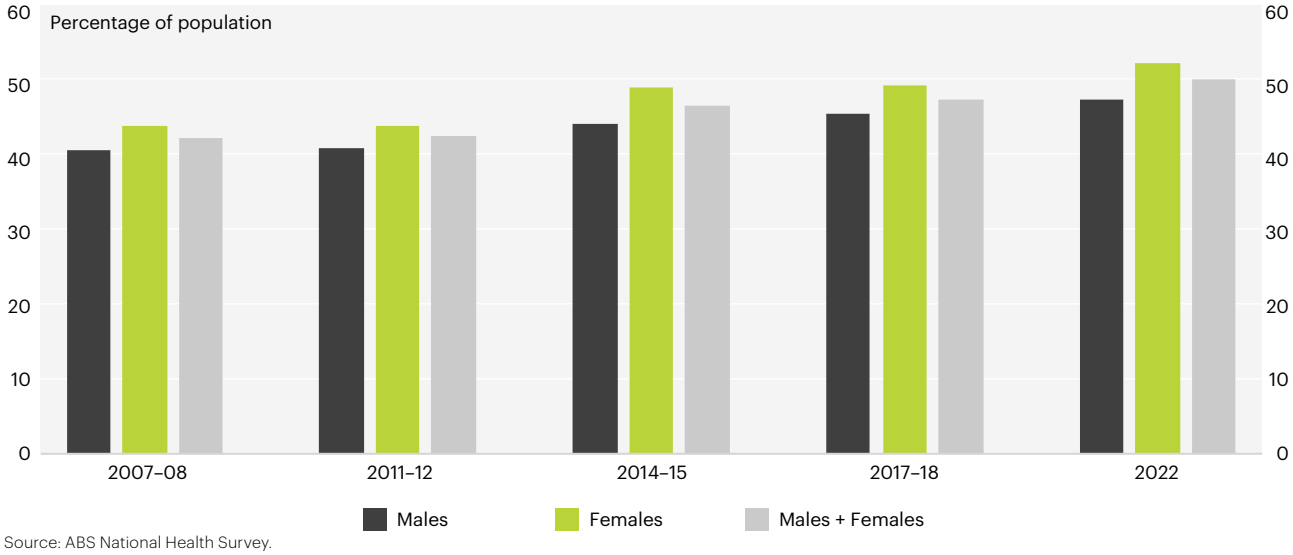
Figure 23: Leading causes of total burden and proportion (%) of total burden by sex, 2024



*COPD: Chronic obstructive pulmonary disease

Source: Commonwealth of Australia, Australian Institute of Health and Welfare. (2023). *Australian Burden of Disease Study 2024.*

Figure 24: Proportion of people with one or more chronic conditions



Source: ABS National Health Survey.

6.6.3 Leading causes of burden

In 2024, the leading causes of burden for men and women were coronary heart disease and dementia (refer to figure 23).[275] In 2022-23, the following three conditions accounted about one-third of spending:[276]

- Cancer ($18.9 billion)
- Cardiovascular diseases ($16.2 billion)
- Musculoskeletal conditions ($15.9 billion)

Cancer also had the highest burden, or human cost of disease, followed by mental health conditions and substance use disorders.[277]

6.6.4 Chronic conditions

As we live longer, people are more likely to develop chronic health conditions. The number of people with one or more chronic conditions has increased from 42 per cent in 2008 to 50 per cent in 2022 – one in two Australians (refer to figure 24).[278] Those reporting two or more chronic conditions has increased from 17 per cent to 22 per cent – one in four Australians.[279] Data reveals disparities in the rates of chronic conditions between men and women, and those living in areas of most disadvantage.[280]

6.6.5 Mental health

Mental health is an increasing burden on the health, wellbeing and productivity of Australians. One in five adults and one in seven young people experienced a mental health disorder in the previous 12 months.[281] Evidence suggests 43 per cent of Australians aged 16-85 had experienced mental illness during their life.[282]

In 2022-23, spending on mental health related services increased from $11.8 billion in 2018-19 to $13.2 billion, with the Australian Government spending approximately $4.6 billion, and state and territory governments spending $8.1 billion[283] Funding for mental health services provided by private hospitals was $823 million, with the non-Commonwealth sourced component about $622 million.[284]

Compared with the general population, people with mental illness are likely to have a lower life expectancy and a higher burden of disease.[285] Almost 80 per cent of premature deaths of people with mental illness are due to preventable physical health conditions.[286]

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07

Recommendations and actions

07

Recommendations and actions

Global and domestic perspectives set out in this blueprint suggests the rapid growth in spending on the health and care economy is unsustainable without comprehensive review and reform. We must address these challenges to ensure we maintain and improve our current health and care system standing and quality of life.

Six key principles

This complex task requires openness and collaboration among a range of stakeholders who are willing to prioritise consumer interests. Given the disparate government funding and regulatory frameworks, a multi-faceted approach is needed to fix our siloed and fragmented systems. The BCA's recommendations are founded on six key principles.

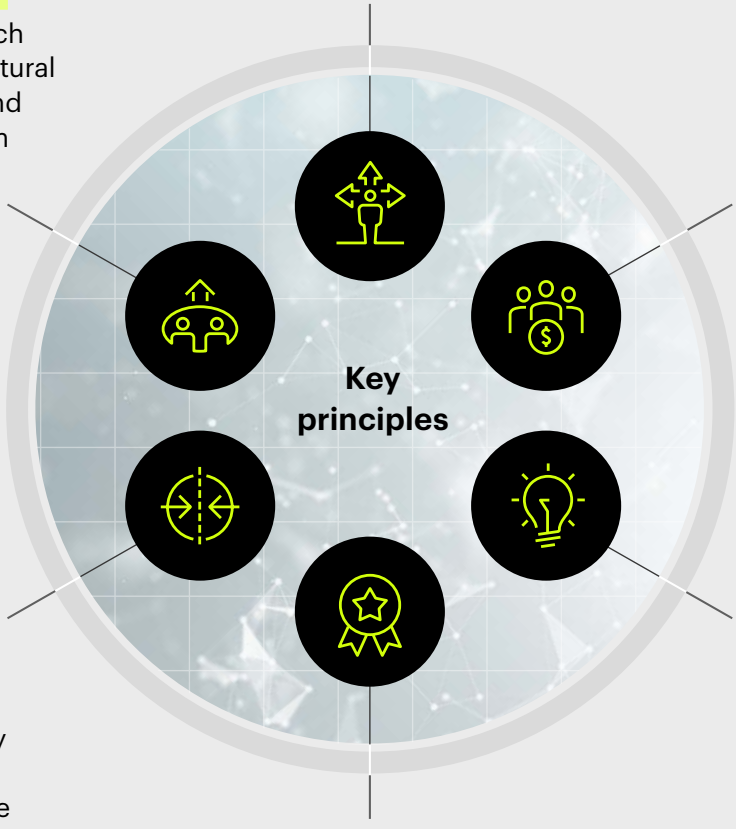
Figure 25: Six key principles

Consumer empowerment

Empower consumers to choose how their care and support needs are met.

A coordinated national approach

Take a unified approach to the long-term structural issues of the health and care economy. Reform cannot happen in isolation; it must consider the full continuum of care for consumers.



Financial sustainability

Implement reforms to support the financial sustainability of the health and care system, and to address intergenerational fairness in the context of an ageing population.

Complementary public and private systems

Build on the strengths of our complementary public and private systems to achieve the best outcomes.

Innovation and technology

Capture the opportunities presented by evidence-based innovations and technologies, working with leading researchers to improve health and care outcomes and productivity.

A skilled workforce

Expand and sustain a highly skilled and trained health and care workforce to meet the needs of our population.

The BCA presents the following recommendations to create an Australian health and care economy that reflects our modern world and innovations and ensure it is sustainable and effective for the future.

7.1 Consumer empowerment

Recommendation 1.

Empower consumers to manage their health and wellbeing by supporting consumer-centred care.

Empowering consumers to proactively manage their health and wellbeing, by responsibly addressing their needs and preferences, increasing transparency in services and utilising new technologies, will improve health literacy and outcomes.

Australians are playing their part by taking a bigger role in their own health and wellbeing. Consumer-centred care (also known as patient-centred care) has been around for many years. This approach leads to better consumer experiences and outcomes.[287]

Our health and care system has made some progress. Consumer choice has been at the forefront of the new *Aged Care Act 2024* (Cth) post the *Royal Commission into Aged Care Quality and Safety*. It is also reflected in the development of specific standards set by national regulators such as the Australian Commission on Safety and Quality in Health Care and the Aged Care Quality and Safety Commission.[288] Many providers have also established Consumer Engagement Committee's recognising consumer feedback is critical.

However, further reform is needed to reconfigure the system and empower consumers to choose how their care and support needs are met. We need to better understand consumer preferences and engage them much earlier in the process. By increasing consumer engagement, we can help them manage their health and wellbeing.[289] This does not mean replacing professional advice but simply guiding consumers so they can make informed decisions.

This blueprint is underpinned by consumer-care principles. We will address coordination and integration across funding, policy and regulation by enhancing transparency and accountability, including the uptake of digital solutions.

7.1.1 National Health Literacy Strategy

Earlier in this blueprint, we outlined the complexities around how care is delivered and funded in Australia. By making the health and care system easier to navigate, Australians can be more confident about managing their own health and wellbeing, particularly where chronic disease is caused by lifestyle behaviours, and treatments may involve non-acute interventions. Evidence suggests that just 40 per cent of adults have the health literacy required to meet the demands of everyday life.[290] In 2018, 33 per cent of Australians found it always easy to discuss health concerns and engage with their healthcare providers; 56 per cent found it usually easy; while 12 per cent found it difficult.[291] Only 26 per cent found it always easy to navigate the healthcare system.[292]

In 2022, the Australian Government consulted on a draft National Health Literacy Strategy.[293] There has been no update since. We suggest the Australian Government should finalise and release the National Health Literacy Strategy with an accompanying action plan to outline how the health literacy of Australians will be improved.

Low health literacy can significantly drain human and financial resources and may be associated with 3-5 per cent of extra costs to the health system.[294]

Launching the national strategy will provide the foundations to improve the health literacy of all Australians and support their understanding and navigation of the system. This will be particularly important with an ageing population and increasing chronic disease burden while tackling increasing demand, with a shortage of workers and finite resources.

Action 1

The Australian Government should finalise and release the National Health Literacy Strategy with an accompanying action plan to outline how Australia will improve the health literacy of its population.

7.1.2 Health literacy education

Our system is difficult to navigate for consumers, policymakers and providers. While there has been some progress, there is much more to achieve. We need to embed health literacy at the earliest opportunity to ensure Australians do not get caught in a fragmented system.

We know low health literacy is often linked to reduced uptake of preventive health measures, increased hospitalisations and poor health outcomes.[295] It also disproportionately affects older adults and culturally and linguistically diverse communities.

Everyone has a role to play in building the health literacy of Australians. It will by necessity be a long-term commitment given ongoing reforms and technological advancements. Social campaigns around early intervention and prevention, health promotion and broader messaging can support this.[296]

Governments should undertake targeted education and communication campaigns to support consumers better understand their health needs and are motivated to take preventative action. This also includes when they do need care, are aware of the options available to them, and know how to access services. Governments should focus on priority populations such as First Nations people, lower socioeconomic status people and people with disability to have greater impact.

Primary care can also enhance health and wellbeing by boosting health literacy and enabling better self-management of chronic disease.[297] This reinforces the importance of strengthening Australia's primary care system and increasing investment in preventive health initiatives to tackle the growing burden of chronic disease. However, there is limited MBS and other types of funding for such activities.

EXAMPLE:

- **Programs:** There are many existing, yet underutilised government funded and supported programs which would support address the health and wellbeing of Australians, such as the Child Dental Benefits Scheme. The Scheme covers part of the full cost of some basic dental services for children.[298]

By raising awareness and improving health literacy, governments will enable consumers to understand what programs are available to them so they can fully access services. This will also support consumers to manage their own health and wellbeing, without the need to navigate an often fragmented health and care system.

Action 2

Governments should undertake targeted education and communication campaigns to support consumers better understand their health needs, and are motivated to take preventative action. This also includes when they do need care, are aware of the available options, and know how to access services. Governments should focus on priority populations to have greater impact.

7.1.3 Transparency supporting informed consumer choice

As health and care services become more personalised and, in some instances, Australians are expected to pay more for their care, consumer demands and expectations will likely increase. It will be important that all stakeholders' support consumer choice by embedding transparency in services, treatments, performance and price.

At its core, reform should prioritise the consumer's experience and their ability to make informed decisions. Clearer information about the price and performance of providers is essential. It will empower consumers to make better choices while driving stronger incentives for providers to improve their performance.[299]

EXAMPLE:

- **Aged care:** This approach will be particularly important when implementing the aged care reforms. To maximise the benefits of reform and gain consumer support for increased contributions to their care, people need to be able to make informed decisions. The My Aged Care Portal is a step in the right direction.[300]

There are a range of existing databases and repositories which hold an abundance of informative information which would be useful to a consumer if it were not only publicly available but also usable.[301]

We welcome the Australian Government's commitment to create greater transparency for consumers by upgrading the Medical Costs Finder website.[302] In 2022, it was released to help Australians find and understand costs for GPs and medical specialists across Australia.[303] But participation was voluntary and uptake has been limited.[304] We welcome the government's announcement to make this compulsory.[305]

However, governments and consumers need to understand and recognise the true cost of delivering and providing services. This is important when considering the cost of a service, including potential out-of-pocket expenses.

Furthermore, consumer trends will change over time with evolving personal preferences and the use of technology. It will be critical to evaluate consumer engagement and transparency reforms to ensure they support best practice.[306] We suggest governments should work with the proposed Australian Health and Care Commission and peak consumer groups to evaluate and monitor consumer engagement and transparency reforms. This will ensure the Australian health and care system embeds evidence-based principles and processes to empower consumers.

Action 3

Governments and providers should empower consumers to choose their own services by increasing transparency on price, performance, treatment options, and expected outcomes as well as improving consumer experiences.

Action 4

Governments should work with the proposed Australian Health and Care Commission and peak consumer groups to evaluate and monitor consumer engagement and transparency reforms. This will ensure the Australian health and care system embeds evidence-based principles and processes to empower consumers.

7.2 Financial sustainability

Recommendation 2.

Build a future health and care system to enable equitable access to services for all Australians.

Building a holistic approach to Australia's health and care economy will establish an adaptable, equitable, and sustainable system. This vision recognises new models of funding and service delivery, ensuring all Australians can access the essential services they need.

Australia must make a significant effort to improve the affordability and availability of health and care services for all Australians. Despite being a top-ranked system overall, we are identified as a low performer on access to care by the Commonwealth Fund, a stark contrast to countries like the UK and the Netherlands.[307] The reality is Australians may face long waits for surgery without PHI, and affordability continues to be a barrier for many. Our mixed public and private health system should not be a deterrent for people to get the care they need.

As we know, funding for health and care is interconnected across a range of mechanisms and the consumer's journey is non-linear, often moving between primary, secondary, tertiary and aged care. To address these complexities, other types of funding models, such as capitated or blended funding, could be enhanced. The *Unleashing the Potential of our Health Workforce – Scope of Practice Review Final Report* has already recommended blended funding to support the delivery of primary care services.[308]

7.2.1 Health and care funding levers

The Tax and Transfer Policy Institute analysis highlights the additional financial pressures on younger Australians, with government spending significantly more on health and care services for older Australians, in real, per-person terms.[309] Therefore, it is important that the Australian Government clearly outlines its funding priorities in the proposed National Health and Care Economy Strategy which will be discussed later.

While Australia strives for universal coverage, we can learn from better-performing countries with low-cost barriers to care and minimum out-of-pocket expenses.[310] Universal coverage ensures any co-payments are small, providing accessible and affordable care.[311]

EXAMPLE:

- **Germany:** Co-payments are capped at 2 per cent of gross income for all consumers and 1 per cent for chronically ill consumers, above which all care is provided.[312]
- **United Kingdom:** The National Health Service provides free public healthcare, including hospital, physical and mental health services.[313]
- **Netherlands:** Visits to primary care, maternity care and child health facilities are fully covered, while other health services are covered by a general social insurance scheme.[314]

In 2022 and 2023, the Australian Government undertook consultations on funding levers, including risk equalisation, PHI incentives (Medicare levy, PHI rebate, Lifetime Health Cover) and hospital default benefits, but has not yet provided a full response.[315] We recommend the Australian Government comprehensively respond to these consultations to help determine if the current settings ensure those who can afford to pay do so fairly for appropriate services.

Since 2014, PHI rebates have continued to decrease, making it harder for consumers to access and pay for services in both public and private systems.[316] The rebate for consumers aged less than 65 years old has reduced from 30 per cent to 24.288 per cent.[317] The Medicare

levy rate is 2 per cent.[318] We also recognise and support the Australian Government's decision to rule out a specific tax or levy to fund age care in response to the Aged Care Taskforce.[319]

A whole-of-system review is crucial to determine if the right settings are in place to address future challenges. We suggest the Australian Government task Treasury or the PC to undertake an economic analysis of all health and care funding levers, including income tax, Goods and Services Tax, Medicare levy, PHI rebate, superannuation and the age pension. This analysis should ensure intergenerational fairness and the long-term sustainability of the system. This goes beyond the current Five Pillars work the PC is undertaking, and ideally is part of a broader tax system review.

As mentioned, broader tax reform and long-term economic competitiveness should be based on three objectives: addressing intergenerational equity, affordably incentivising business investment, and making the tax system simpler and more sustainable.

Action 5

The Australian Government should comprehensively respond to the outstanding consultations from 2022 and 2023 on risk equalisation, private health insurance incentives, and hospital default benefits.

Action 6

The Australian Government should task Treasury or the Productivity Commission to undertake a whole-of-system economic analysis on the range of health and care funding levers to ensure intergenerational fairness and the system remains sustainable.

7.2.2 Australian Health and Care Planning and Delivery Agency

Australia's federated system creates challenges, with health and care policy often becoming a political issue. It is important health and care infrastructure spending is depoliticised. We also face significant long-term challenges, including an ageing population and increasing burden of chronic disease, all with limited resources and funding.

There is currently a lack of strategic collaboration between both the public and private sectors regarding the services Australians needs. The *Mid-term Review of the NHRA* noted a need for improved transparency and reporting on public health funding.[320]

The *NSW Special Commission into Healthcare Funding* also provided several recommendations on the planning and delivery of services, emphasising that not all services can or should be provided everywhere.[321] Key recommendations included:[322]

- A transparent, committed and collaborative approach to coordinated system-wide service planning.
- Planning processes must identify the health needs of a community, the capabilities of non-public providers, and gaps the public health system should fill.
- Ongoing collaboration with the community and other providers to determine emerging service gaps and needs, and to identify all available funding streams.
- Capital planning must be an integral part of this process, ensuring that decisions on new or upgraded facilities reflect an assessment of the population's health needs and the most efficient way to deliver services.

We propose that the Australian Government establish the Australian Health and Care Planning and Delivery Agency to provide independent advice on the planning and delivery of health and care services across Australia. This agency would have a flexible operating model to meet the needs of local populations and work closely with all governments and private providers.

The proposed agency would have responsibility for:

- Commissioning services in consultation with local health networks and private providers.
- Leading and driving service plan delivery, including government funding considerations.
- Overseeing service planning and delivery across health, disability and ageing.
- Data and information that supports service planning and delivery.
- National workforce planning and oversight across health, disability and ageing.

The Australian Government's Integrated Care and Commissioning Initiative, which trials new models of care, could also become the responsibility of this proposed agency.[323]

These responsibilities would require the agency to take a broad holistic approach to service planning and delivery across health, disability and ageing.

Action 7

The Australian Government should establish the Australian Health and Care Planning and Delivery Agency to provide independent advice on the planning and delivery of health and care services.

7.2.3 Australian Health and Care Pricing Authority

The Independent Hospital Pricing Authority was established in 2011 to provide independent and transparent advice to the Australian Government on public hospital funding.[324] In 2022, its remit was expanded to include residential aged care services, and it was renamed the Independent Health and Aged Care Pricing Authority (IHACPA), in response to the *Royal Commission into Aged Care Quality and Safety*.[325]

This blueprint outlines the intricacies between the health, disability and ageing sectors, and their competition for a similar workforce. Significant pricing disparities for NDIS services have led to an increase in health and care workers transitioning from health and aged care to the NDIS.[326]

Anecdotal evidence also suggests that the higher pricing of NDIS services has created a market for new businesses, which has resulted in a loss of much-needed community health services.[327] A re-evaluation of pricing is necessary to ensure market equilibrium.

We recognise the Australian Government has requested that IHACPA undertake preliminary work to identify opportunities for future reforms to NDIS pricing, which is a crucial step.[328] We propose that the Australian Government rename IHACPA to the Australian Health and Care Pricing Authority, with an expanded mandate to provide independent and transparent advice to governments and the market on the pricing for services across health, disability and ageing.

The recent NDIS Review called for reforms to pricing and payments to improve provider incentives to deliver quality services.[329] It also recommended that IHACPA be given the responsibility to advise on NDIS pricing.[330]

The Australian Government may also wish to provide the new authority responsibility for assessing and approving annual PHI premiums. This would provide responsibility to an independent authority and alleviate political pressures each year for the Minister to make this decision.[331]

Action 8

The Australian Government should rename the existing Independent Health and Aged Care Pricing Authority to the Australian Health and Care Pricing Authority and expand its remit to provide independent and transparent advice on pricing for services across health, disability and ageing.

Action 9

The Australian Government may wish to provide the Australian Health and Care Pricing Authority with responsibility to assess and approve annual private health insurance premiums.

7.2.4 Australian Institute of Health and Welfare

Established in 1987, the Australian Institute of Health and Welfare (AIHW) provides quality reports and information on key health and welfare matters to improve the delivery of services for Australians.[332] Health and care systems have an abundance of data and information which will grow exponentially with the increased use of technology.

We recognise the range of AIHW databases and the Australian Government's Measuring What Matters Framework, which is our first national wellbeing framework.[333] However, Australia does not effectively leverage or use this data to plan or deliver services.[334] This is supported by the *Mid-term review of the NHRA* which recommended the AIHW be primarily responsible for developing nationally consistent data standards, data collection and reporting for the health system performance framework.[335] The recent PC

Closing the Gap report also outlined ongoing data limitations.[336] Previous PC reports have identified data collection and reporting as an issue.[337]

We suggest that National Cabinet should agree to the AIHW to undertake a strategic review of current reporting requirements and data repositories. This review would identify gaps and determine whether any existing data no longer needs to be reported. This is a crucial task as we embark on significant investment in digital technologies. It will ensure that the appropriate data is being collected to provide stakeholders with the necessary evidence to deliver health and care services.

The most recent *Private Health Establishments Collection* was undertaken by the Australian Bureau of Statistics in 2016-17.[338] Current data is limited which hinders the market's ability to invest and determine if there are a sufficient number of beds and services.

Action 10

National Cabinet should agree to the Australian Institute of Health and Welfare to undertake a strategic review of current reporting requirements and data repositories to identify gaps and redundancies.

7.2.5 Primary care

Australians are finding it increasingly difficult to access and afford preventative and primary healthcare services.[339] These challenges are even greater in regional, rural and remote areas, including for First Nations people.[340] This is a significant issue given our ageing population and the increasing prevalence of chronic diseases, which will require Australians to be more aware of and be able to manage their care needs.

Primary care is the most appropriate vehicle for delivering these services, and we should be focused on rebuilding the connection with health and care services at the community level. The OECD found strong gatekeeping, high continuity of care and financial incentives for quality demonstrated lower rates of avoidable hospital admissions.[341]

7.2.5.1 Primary Health Networks (PHNs)

PHNs aim to improve the delivery of primary care in their regions by commissioning services to meet the specific health priorities of local communities.[342] However, PHNs do not deliver or operate these services, which risks further exacerbating system fragmentation.[343]

While the intention behind PHNs is good, it is unclear whether they are effective in supporting a consumer-centred care approach. From 2015-16 to 2022-23, the Australian Government provided $11.6 billion in grants to PHNs.[344] An Ernst & Young evaluation found PHNs delivered value by improving integration and addressing service needs but also noted challenges for other agencies engaging in regional planning.[345]

In contrast, the Australian National Audit Office (ANAO) found the Department of Health and Aged Care to have only been partly effective in its performance management of PHNs, providing eight recommendations to address transparency, accountability, governance and data, and noted that the department had not demonstrated that the PHN delivery model was achieving its objectives.[346]

On the surface, PHNs ability to commission local services across seven priority health areas for local communities is a flexible model.[347] However, COVID-19 highlighted challenges and gaps in PHN service delivery and communication between primary care, tertiary care and aged care.[348]

The BCA acknowledges that the Australian Government is currently reviewing the *PHN Business Model and Mental Health Flexible Funding Model*.[349] This review should include an assessment of whether its governance and structure are effective compared to other options. We also recognise the PC's interim report into *Delivering quality care more efficiently* which suggests governments embed collaborative commissioning by reducing fragmentation in healthcare to foster innovation, improve care outcomes and generate savings.[350] This includes new governance and funding arrangements.

The Australian Government should consider the PC's interim findings into *Delivering quality care more efficiently* for collaborative commissioning in its current review.[351] The review needs to determine whether the PHN operating model is appropriate for its performance expectations and supports a whole-of-system approach.

While we support the policy intention of collaborative commissioning, we do not support the proposal put forward by the PC.[352] This proposal does not appear to address the underlying issue of fragmented services, rather it appears to create red-tape and bureaucracy.

State and territory governments, along with local health networks, may be better positioned to lead commissioning efforts, given their existing role in delivering a broad range of community-led services. This is supported by the *NSW Special Commission into Healthcare Funding* which recommended that NSW Health should, via the relevant local health district, deliver adequate primary care in communities with a lack of access.[353]

We propose that in time, the Australian Government transition away from PHNs and provide this responsibility for commissioning services to a new entity such as the proposed Australian Health and Care Planning and Delivery Agency. This would not only reduce the number of boards and executive management positions but also provide greater responsibility to state-led services, which already delivery many of these services. It could also improve incentives and outcomes by effectively integrating services across primary, tertiary and aged care.

We do support the PC's recommendations for more flexible funding models to enable the implementation of cost-effective community-led services and to work more closely with Aboriginal Community Controlled Health Organisations.[354] As such, the proposed agency could lead this work.

Action 11

The Australian Government should consider the Productivity Commission's interim findings into *Delivering quality care more efficiently* for collaborative commissioning in its *Review of Primary Health Network Business Model and Mental Health Flexible Funding Model* to determine whether the right operating model is in place to support a whole-of-system approach.

Action 12

In time, the Australian Government should transition away from Primary Health Networks and provide the responsibility for commissioning services to a new entity such as the proposed Australian Health and Care Economy Planning and Delivery Agency. This would reduce bureaucracy and provide greater responsibility to state-led services.

7.2.5.2 General practice

We need to focus our investment on primary care rather than more costly secondary and tertiary care, which is why governments have increased the number of Urgent Care Clinics (UCCs).

The Australian Government has committed nearly $1 billion to establish 87 UCCs, with a further $644 million in funding announced to open an additional 50 clinics.[355] We recognise the recent *Evaluation of the Medicare Urgent Care Clinics: Interim Evaluation Report 1* but note its limitations.[356] Two further reports are scheduled for release at the end of 2025 and 2026.[357] It is important that the broader implications for the primary care sector are considered before further investment is made.

UCCs were intended to be open for extended hours (8am to 10pm), but many are not, nor are they co-located with emergency departments, which undermines their purpose to alleviate pressure on already overstretched emergency departments.[358] Data also remains limited to assess the impact of UCCs on emergency departments.[359]

The focus should also be on whether a consumer would have attended their regular GP if the practice was open. A key criticism is that UCCs may break an important link between a consumer and their regular GP, potentially adding more demand to an already stretched workforce.[360] Furthermore, many UCCs do not have the ability to deliver radiology or pathology services after 5pm or on weekends, which means that consumers may still end up in the emergency department.[361] Many of these services are operated by a separate provider. State governments are also establishing their own UCCs, adding to the complexity.[362] The Victorian Government has invested a further $27 million to continue 12 Urgent Care Clinics across Victoria leading to further duplication and

confusion for consumers, in what should be the key entry point into the health system.[363]

New models of care also allow for the delivery of services such as dialysis and chemotherapy in a community clinical setting, reducing the need to build large hospitals and placing a larger emphasis on primary care. International examples demonstrate how community health centres can improve access to primary health services.

EXAMPLE:

- **Canada:** In Ontario, Community Health Centres (CHCs) are not-for-profit organisations that provide comprehensive primary care services, including medical, dental, and mental healthcare. CHCs are designed to address the social determinants of health by offering services such as housing support and nutrition counselling.[364]
- **United Kingdom:** The National Health Service in partnership with local councils, is developing Health and Wellbeing Hubs to deliver cost-effective, preventative services. They aim to reduce health inequities by helping people make lifestyle changes.[365]

We suggest that the Australian Government consider the following as part of its next evaluation of UCCs:

- A cost comparison of UCCs versus the emergency department.
- A cost comparison of UCCs versus a community-led GP practice, and whether incentives can be adjusted to ensure more GPs are open after-hours.
- Whether the concept of UCCs can be expanded to broader community health centres that provide a range of other services, such as dialysis and chemotherapy, to alleviate pressures on inpatient hospital settings.

While we acknowledge UCCs have been beneficial to many consumers, their introduction does not align with the continuity-of-care principle that underpins primary care.[366] Evidence suggests maintaining the same health professionals is good for the consumer as it builds a strong relationship with a team that has an extensive understanding of the consumer's clinical history.[367] Greater transparency in evaluations will enable more informed comparisons.

We also recognise the *Effectiveness Review of General Practice Incentives* and the Expert Advisory Panel report to the Australian Government which looked at current primary care incentives.[368] This supports the *Strengthening Medicare Taskforce Report* which outlined a vision to strengthen Medicare.[369]

Separately, we understand the ongoing cost-of-living pressures impacting consumers' ability to seek healthcare support. The Australian Government announced that it would be tripling the GP bulk-billing rate for people aged 16-64, commencing 1 November 2025.[370] This follows a previous decision to increase the bulk-billing rate for children under 16 and for Australians aged 65 and over.[371]

Given the significant fiscal implications, the Australian Government should evaluate the effectiveness of increasing the bulk-billing rate for 16-64 years-olds, 12 months after implementation. This evaluation should determine whether the increased rate was applied to the right type of consultations or whether it needs to be changed, particularly in recognition of the increasing rate of chronic disease.

Action 13

The Australian Government should consider the following as part of the next evaluation of Urgent Care Clinics (UCCs): cost comparisons of UCCs versus emergency departments and community-led GP practices, and whether UCCs can be expanded to provide a broader range of community-led services.

Action 14

The Australian Government should evaluate the effectiveness of increasing the bulk-billing rate for 16-64 years-olds, 12 months after its implementation, to determine if the increased rate was applied to the right types of consultations.

7.2.6 Private health

The public and private systems are fundamental components of Australia's health and care system. Nearly half of all Australians have some type of PHI, enabling them to access the care they need and alleviating pressure on the public system (refer to figure 8).[372]

7.2.6.1 Private health insurance products

In 2019-20, the Australian Government introduced significant reforms to PHI, including product tiers (gold, silver, bronze and basic) designed to mandate minimum service coverage.[373] However, no comprehensive evaluation has been conducted to determine the effectiveness of these reforms or their potential unintended consequences. The BCA suggests that the Australian Government should first conduct an independent and formal evaluation of the 2019-20 PHI reforms, including product design and coverage.

The BCA acknowledges the Australian Government's *Private Hospital Sector Financial Check*, which identified several factors impacting the financial viability of private hospitals.[374] These include workforce shortages, revenue lagging behind inflation, increased input costs, and capital expenditure delays due to COVID-19.[375] The Australian Government must ensure that any future proposals address the issues identified in this check and continue to respond to its findings.

While the BCA recognises the cost challenges related to mental health and maternity services, any changes must be supported by evidence demonstrating that they will lower or maintain premiums and increase access for consumers. Making fundamental changes to the underlying structure of PHI to address these two areas could risk the entire system. Unintended consequences, such as increased premiums, could lead to a vicious cycle of Australians dropping their insurance, putting further pressure on premiums for a smaller membership.

Before making any substantial changes as proposed by the Private Health CEO Forum, the BCA strongly encourages the Australian Government to undertake a more detailed assessment of mental health and maternity services, particularly in regional, rural and remote areas.[376] This detailed assessment should:

- Include detailed economic and behavioural modelling to determine whether extending maternity or mental health services to other tiers would increase or decrease costs for consumers and what the financial impact would be on private health insurers and private hospitals.
- Consider the cost of delivering these services and associated out-of-pocket expenses, including for anaesthetists, paediatricians, psychiatrists, and obstetricians.

We recognise the Australian Government consulted on potential solutions earlier this year, with no formal public response to date.[377]

The *Private Health Insurance Act 2007* (Cth) is the main legislation governing PHI.[378] Given Australia's changing disease profile and ageing population, the Australian Government should review this Act to determine whether it remains fit for purpose. Previous PC reports have noted the limited ability for PHIs to fund other services.[379]

Action 15

The Australian Government should first conduct an independent and formal evaluation of the 2019-20 private health insurance reforms, including product design and coverage.

Action 16

The Australian Government must ensure that any proposals or solutions address the issues identified in the Private Hospital Sector Financial Check and continue to respond to its findings.

Action 17

The Australian Government needs to undertake a detailed assessment of mental health and maternity services to model the potential financial impacts of any proposed changes on consumers, insurers and hospitals before making substantial reforms, particularly in regional, rural, and remote areas in both the public and private settings.

Action 18

The Australian Government should review the *Private Health Insurance Act 2007* (Cth) to determine whether the legislation is still fit-for-purpose, given the changing disease profile and ageing population.

7.2.6.2 Transparency in private health

Greater transparency in the health and care sector is needed to drive efficiencies, accountability, and scrutiny of cost structures, and to facilitate a shift towards a consumer-led model. The administration and understanding of PHI should also be simpler.

A variety of existing datasets provide information into the sector's performance, such as the Hospital Case Mix Protocol, the Private Hospital Bureau, and the National Hospital Cost Data Collection Private Sector.[380] In addition, reporting requirements like Certificate B, and C and the Nursing Home Type Patient Acute Care Certification, contribute to oversight.[381] However, consideration should be given to streamline these processes to reduce the administrative burden.

The sector continues to express concerns about the ECLIPSE system, which supports providers in determining and communicating PHI coverage to consumers, and in submitting simplified billing claims.[382] While it helps reduce the number of post-hospitalisation accounts received by the consumer, the system requires enhancement to align with current PHI products and to more clearly indicate coverage status. To improve transparency and efficiency in private health, the Australian Government should consider measures to reduce administrative burden and costs for private health insurers and hospitals. This could include streamlining regulation and legislative requirements, enhancing technology interoperability across the sector, particularly the ECLIPSE system and explore the expansion of IHACPA's Private Hospital Costing Dataset Collection to include all private hospitals, supported by extensive consultation.

We also acknowledge the Australian Government's efforts to enhance transparency in aged care, providing consumers with easy-to-access information, including pricing, on the My Aged Care Portal.[383] Stakeholders may consider whether a similar platform, a My Private Hospital Portal, could be developed. Governments will need to consider existing data sets, reporting requirements and the public interest in greater transparency. This approach should be considered across the entire health and care economy, including public hospitals and the NDIS.

While a wealth of data on the PHI industry is publicly available, policy can still be complex and burdensome for consumers and healthcare professionals. Clearer, more concise messaging would help Australians better understand the benefits of PHI. For example. greater transparency around the number of Australians holding specific levels of cover is also crucial. We recognise the Australian Prudential Regulation Authority (APRA) currently publishes quarterly statistics on PHI.[384] We suggest the Australian Government and the Australian Prudential Regulation Authority release as part of the quarterly statistics the number of Australians holding each level of cover (gold, silver, bronze and basic). This information will provide valuable insights for private health insurers and private hospitals to plan and deliver services more effectively. We recognise some of this information has previously been published.[385]

We also suggest the Australian Government assign responsibilities related to private health (such as premium rounds) to either the proposed Australian Health and Care Pricing Authority, the Australian Health and Care Commission or the Australian Health and Care Planning and Delivery Agency. The specific roles and responsibilities can be determined through extensive consultation, but this would ensure independent, evidence-based decisions are made. We recognise the Private Health Insurance Ombudsman is an independent service within the Commonwealth Ombudsman that handles complaints and offers advice to stakeholders.[386]

Action 19

The Australian Government should consider measures to improve transparency and efficiency in private health by:

- Streamlining government regulation and legislative requirements for the private sector.
- Enhancing technology interoperability across the sector, including the ECLIPSE system.
- Expanding the Independent Health and Aged Care Authority's Private Hospital Costing Dataset Collection to include all private hospitals.
- Considering the development of a My Private Hospital Portal to provide consumers with more information, including pricing.
- Publicly releasing the number of Australians holding specific levels of private health insurance cover as part of quarterly updates.

Action 20

The Australian Government should assign responsibilities related to private health to either the proposed Australian Health and Care Pricing Authority, the Australian Health and Care Commission or the Australian Health and Care Planning and Delivery Agency. Specific roles can be determined through extensive consultation

7.2.6.3 National Private Price

We recognise the ongoing challenges in private health, and we need to ensure Australia continues to have a thriving private system. A decade ago, all governments agreed to transition to activity-based funding for public hospitals and established a National Efficient Price and National Weighted Average Unit.[387] This has enabled greater transparency in the public setting, though, there are still improvements which could be made.

We are aware of calls to establish a National Private Price for private health.[388] Careful consideration is warranted on market intervention. While we understand the intention of this policy, we suggest a thorough economic analysis be undertaken to determine whether a National Private Price or National Private Weighted Average Unit is feasible before implementation. The analysis needs to recognise the differing funding structures compared to the public system as well as the cost differences between for-profit and not-for-profit providers.

Given the complex nature of the funding levers and policies, any pricing reform risks further exacerbating the current problems, reducing consumer access and increasing pressure on the public system. Other impacts to consider include consumer access, insurer coverage and viability, and private hospital viability. Reform needs to be carefully designed to reflect the true cost of delivering care.

As mentioned, there are likely other avenues which could be explored including contract terms and conditions, and arrangements and benefit structures. Australia thrives on a public and private system, and any reform should ensure it supports this fundamental characteristic.

Action 21

An economic analysis must be undertaken to determine whether a National Private Price or National Private Weighted Average Unit is feasible for private health before implementation. The analysis needs to recognise the differing funding structures compared to the public system as well as the cost differences between for-profit and not-for-profit providers.

7.2.6.4 Use private health more effectively

Our public health system continues to face increased demand. A solution can, in part, be found by better utilising the private system. To ensure consumers still see the benefit and value in private health insurance, governments need to consider how they can effectively utilise latent capacity in the private sector.

We suggest the Australian Government provide incentive payments to state and territory governments through the NHRA. These payments would be for governments that utilise private capacity for consumers who have exceeded the clinically approved wait time for elective surgery.[389]

This approach would reduce demand on the public system, provide activity for the private sector, and ensure consumers have their health needs addressed within a reasonable timeframe. Governments may also wish to explore other arrangements to ensure both public and private capital are being effectively used, noting the ongoing fiscal pressures and workforce challenges.

Action 22

The Australian Government should provide incentive payments to state and territory governments through the National Health Reform Agreement for the utilisation of private capacity for consumers who have exceeded the clinically approved wait time for elective surgery.

7.2.7 Aged care

According to the *Intergenerational Report 2023*, there will be a major shift in service needs as baby boomers increasingly rely on aged care services.[390]

The BCA recognises the bipartisan approach to address aged care funding challenges through the *Aged Care Act 2024* (Cth).[391] This Act is a significant step towards better aligning the system so that those with the capacity to pay can contribute to their care.

The reforms will require consumers to contribute more to non-clinical care based on their income but will also provide more support in the home.[392] Residential providers will also receive more funding to support major capital expenditure to upgrade and expand facilities.

This is a complex reform, and we acknowledge the government's decision to defer the commencement of the Act and new Support at Home arrangements from 1 July 2025 to 1 November 2025.[393] This deferral is important to ensure a successful implementation and to continue building trust in the program's design.

7.2.7.1 Coordination

There is a significant and direct connection between the health and aged care systems.[394] Delays in transitions are often blamed for a lack of available hospital beds, residential aged care beds or home care packages; a political and policy issue that continues to be a point of contention between the Australian and state and territory governments.[395] This impacts both the public and private settings and similar issues are also faced with the NDIS.

We suggest the proposed Australian Health and Care Planning and Delivery Agency play a stewardship role supporting better coordination, planning and delivery of services across health, disability and ageing. This issue needs to be addressed through better management and coordination, alongside increased and faster access to aged care services (support in the home and residential care) and NDIS places. There is currently too great an incentive for different parts of the system to cost-shift from one part to another, with patients and ageing Australians stuck in the middle without the appropriate care that they deserve.

Action 23

The proposed Australian Health and Care Planning and Delivery Agency play a stewardship role in supporting better coordination, planning and delivery of services across health, disability and ageing.

7.2.7.2 Digital and capital investment

We recognise the funding reforms should alleviate some of the financial cost pressures on the sector, particularly in residential aged care. This is a significant stride towards addressing some of these pressures, but they are not a complete solution. It will take time to fully appreciate their effectiveness.

It should be noted that the reforms also come with increased costs for providers, with limited financial support to offset significant digital system upgrades. The proposed Digital Health and Care Interoperability Fund could support these efforts.

Another significant challenge is the supply of better-quality aged care accommodation. There remains insufficient capital investment to build and upgrade residential aged care homes.[396] The sector also faces similar challenges to the broader housing market, including insufficient supply, approval delays, rising construction costs and a shortage of construction workers. Stamp duty further hinders individuals from downsizing to units or retirement villages.

One of the primary challenges is slow approval times for new developments. This issue was highlighted in the BCA's report, *It's time to say yes to housing*, which recommends planning approval changes to expedite projects.[397] All governments should address these recommendations, including to prioritise residential aged care facilities and workforce accommodation, particularly in regional areas.

Evolving community expectations also add to the problem. People no longer accept the multi-shared rooms that were part of a previous generation of residential aged care homes. If we expect people to make a greater contribution to their aged care, they will expect greater choice and quality.

Action 24

The Australian Government should utilise the proposed Digital Health and Care Interoperability Fund to support the enhancement of digital systems within the aged care system.

Action 25

All governments should address the recommendations of the BCA's report, *It's time to say yes to housing*, which recommends planning approval changes to expedite projects. All governments should address these recommendations, including to prioritise residential aged care facilities and workforce accommodation, particularly in regional areas.

7.2.7.3 Alternative methods to pay

Australia's ageing population, combined with older Australian's desire to remain in their own homes for longer, will require increased contributions to cover those costs. The need for aged care services has increased dramatically in recent years. Despite this growing demand, supply has been constrained, with 120,000 Australians waiting for a Home Care Package.[398] Wait times for higher-level packages can exceed 12 months.

As the *Royal Commission into Aged Care Quality and Safety* identified, the funding and structure of the aged care system is unsustainable.[399] We support the Aged Care Taskforce's recommendation against introducing a new, specific tax or levy to fund aged care, a key recommendation of the *Royal Commission*.[400] Australia already relies heavily on personal income tax, and another tax would not address the existing intergenerational inequities.

Instead, the Australian Government should explore other ways for those who have the capacity to pay, to fund their aged care through a greater variety of financial products. Superannuation was introduced to support people when they retire. Yet, people are not utilising these funds. Flinders University notes that compulsory long-term care insurance exists in other countries but would be innovative for Australia.[401]

There is also potential for a broader range of financial products, such as annuities, which set aside a specific amount for aged care. Life insurers are well placed to provide valuable propositions, including annuity solutions, that support the income needs of Australians requiring home or residential care.

We recognise APRA has announced a consultation process on capital expenditure for annuity products.[402] By reducing the capital expenditure requirements for annuity products, APRA is considering reforms that would incentivise the manufacture of competitive annuity products.[403] This is a critical first step towards solving the government's growing age pension and aged care funding challenges.

Australia's insurance market currently provides default insurance cover to over 8.5 million members and could effectively provide members with access to these types of products.[404] The Australian Government should work with industry to determine insurance benefit designs, including annuity solutions, that could supplement the income needs of Australians. For example, members of annuity products could convert accumulated savings into lifetime income streams, with optional features to 'top-up' income once eligibility criteria are met.

Action 26

The Australian Government should explore other ways for those who have the capacity to pay, to fund their aged care through a greater variety of financial products.

Action 27

The Australian Government should work with industry to determine insurance benefit designs, including annuity solutions, that could supplement the income needs of Australians and support the government's growing aged care funding challenge.

7.2.8 Alternative models of care and funding

Alternative models of care, including Hospital-in-the-Home (HITH) and preventative measures, will help reduce hospitalisation rates and enable our health and care professionals to

work more efficiently. We must move from a focus on fixing health problems to preventing them or treating them earlier. Despite the significant benefits of prevention, our current health and care activities continue to focus on acute care rather than preventative and community health.[405]

Over the past decade, state and territory governments have invested heavily in new buildings and facilities to meet increasing demand. However, there has been little consideration for funding alternative settings or moving services into the community. In recent years, day-only private hospitals have emerged as a response to procedural improvements that result in shorter hospital stays.

7.2.8.1 Hospital and care in the home (HITH)

More Australians are receiving care in their home, a model that would prefer to be receiving by consumers, and be cheaper than traditional inpatient services. However, funding for these types of services is inconsistent across the health and care economy. Studies in Australia have shown that HITH can be significantly more cost effective than in-hospital care for appropriately selected patients.[406]

Governments should support and scale proven new models of care, including HITH and associated funding arrangements. These models must be clinically appropriate, improve consumer access, quality and experience, and not simply shift costs from one area to another. The proposed Australian Health and Care Planning and Delivery Agency will be able to provide governments and the market with advice on whether more built infrastructure is necessary.

While public services are increasingly offering services at home, private consumers are not guaranteed coverage for these services due to restrictive legislation and rules.[407] This creates an imbalance that limits consumer choice. The BCA believes hospital and care-in-the-home services should be covered regardless of whether they are in the public or private setting.

The Australian Government may wish to provide the proposed Australian Health and Care Commission and the proposed Australian Health and Care Planning and Delivery Agency with the responsibility to accredit new models of care and determine where these services are needed based on population needs.

Recent aged care reforms also commit to increasing funding for care-in-the-home services, allowing older Australians to stay at home longer. These services will be critical to easing pressure on residential aged care beds.

Action 28

Governments should support and scale proven new models of care, including hospital-in-the-home, and associated funding arrangements across the health and care system. These should be clinically appropriate, improve access, quality and experience.

Action 29

The Australian Government may wish to provide the proposed Australian Health and Care Commission and the proposed Australian Health and Care Planning and Delivery Agency with the responsibilities to accredit new models of care and determine where these services are needed.

7.2.8.2 Virtual health, including telehealth and remote monitoring

Reduced travel time from greater use of telehealth is delivering consumer gains of about $895 million per year.[408]

Telehealth and remote monitoring can further transform the health and care system by enabling consumers to receive care at home.[409] Models of care and innovation that were not thought possible just a decade ago are now widely available.

Devices and apps allow consumers to be remotely monitored by health and care professionals and to more easily manage their own chronic conditions, such as diabetes.

Growth in the health and medical technology industry is expected to continue as advances are made in areas like remote monitoring and wearable devices. Australia is well-positioned to become a leader in genomic medicine, medical technology, AI and digital heath, all of which will improve health outcomes.

While Australia sets high standards for these technologies, we must ensure they align with international standards and do not hinder Australians' access to the latest innovations. The way these technologies are regulated, particularly with the incorporation of AI, will be critical to achieving the best care outcomes.

At the same time, we must ensure there are sufficient safeguards. The Australian Government, in partnership with clinical bodies, needs to develop robust virtual care standards to ensure the safety and quality of services and support their broader uptake.

Telehealth and remote monitoring will not replace face-to-face services. To enable the efficient delivery of these services, governments need to leverage leading existing providers rather than duplicating services. The Australian Government should incentivise state and territory governments to utilise virtual health, including telehealth and remote monitoring, more effectively for high-cost hospital care, reducing demand for inpatient services. This could be addressed through the National Health Reform Agreement.

EXAMPLE:

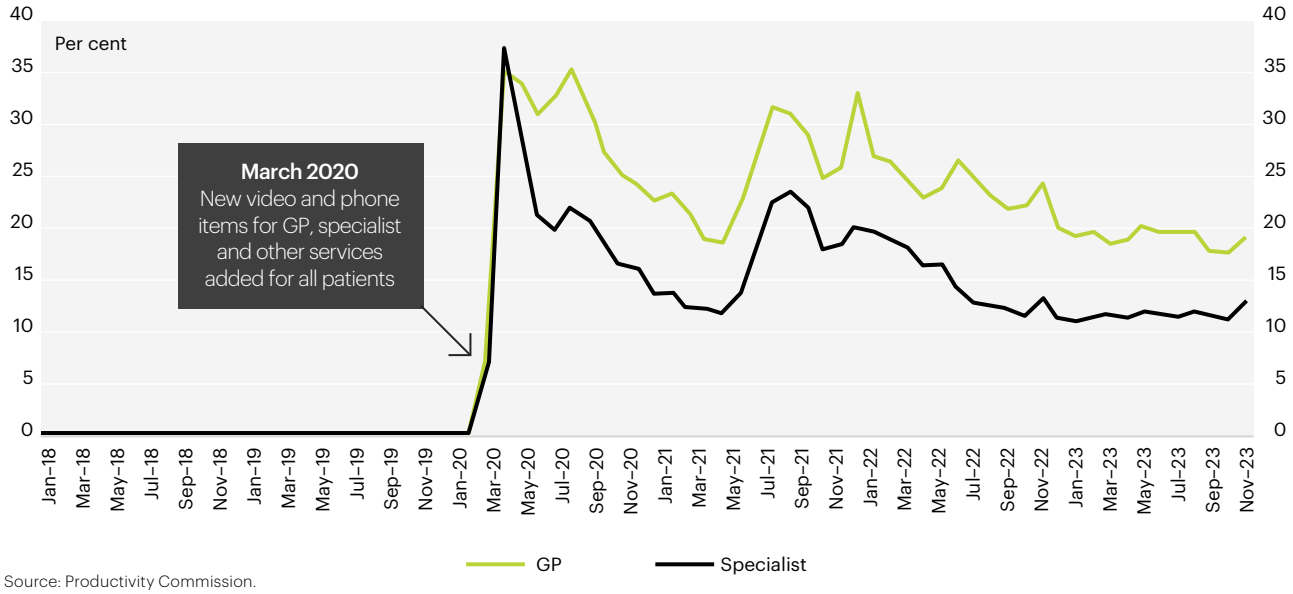
- **Tech:** In NSW, RPA Virtual Hospital delivers hospital care to consumers in their homes via video and phone. Consumers may be required to use technology to help the care team monitor their health remotely.[410]
- **At home:** Nationally, Ramsay Connect delivers comprehensive, multidisciplinary care for consumers transitioning home or in need of support following hospital admission. Services include rehab at home, hospital care at home and virtual health.[411]

Building new infrastructure is expensive. While hospitals will always be needed, some services can now be delivered in alternate settings. Innovations like those described above increasingly support the delivery of sustainable services in the comfort of a consumer's home.

All governments need to minimise the unintended consequences of restrictions on the use of technology. Careful calibration of incentives and subsidies is critical to managing costs and ensuring they target appropriate care without impacting face-to-face services. The Australian Government should develop sustainable funding incentives for telehealth and remote monitoring services to support their provision across the broader health and care economy.

The BCA recognises the MBS Review Advisory Committee's *Telehealth Post-Implementation Review* and its recommendations.[412] The review found that those who are less likely to use telehealth may be the ones who would benefit most from it, including men, people over 70, those of lower socioeconomic status, and those living in regional and remote areas.[413] This is an important

Figure 26: Share of all Medicare-funded GP and specialist consultations that took place via telehealth, 2018-23



Source: Productivity Commission.

finding for all providers when considering the broader implementation of telehealth.

The announcement by the Australian Government to speed up internet services through the NBN should support the further roll out and uptake of these services, helping to address the metropolitan and regional divide.[414]

Consumer-driven digital innovations like telehealth, digital therapeutics and remote monitoring are enabling Australians to access care from home. These services have seen rapid growth, with nearly one in five Medicare-funded GP consultations and one in 10 specialist consultations now conducted by phone or video (refer to figure 26).[415] This shift has delivered significant consumer gains, with the PC estimating approximately $895 million per year in reduced travel time alone.[416]

Action 30

The Australian Government, in partnership with clinical bodies, needs to develop robust virtual care standards to ensure the safety and quality of services and support their broader uptake.

Action 31

The Australian Government should incentivise state and territory governments to utilise virtual health, including telehealth and remote monitoring, more effectively for high-cost hospital care, reducing demand for inpatient services. This could be addressed through the National Health Reform Agreement.

Action 32

The Australian Government should develop sustainable funding incentives for telehealth and remote monitoring services to support their provision across the broader health and care economy without impacting delivery of face-to-face services.

7.2.8.3 Quality versus quantity payments

Much of Australia's health and care system is built on an activity-based and fee-for-service funding models, where a provider is paid a fee for each service delivered. This system does not adequately account for the quality of care or outcomes, and can penalise providers who deliver more than they are funded for.

This model is outdated for the challenges Australia now faces and hinders the alignment of funding with quality outcomes across the system. While some measures exist, such as penalties for readmissions in public hospitals, a broader shift is needed.[417]

Over 61 per cent of Australians live with at least one long-term health condition, with mental health and back problems being the most common chronic conditions.[418] We must transition our funding models to prioritise quality over quantity in preventative health and chronic disease management.

We acknowledge the Australian Government's commitment to reform MBS items for chronic disease management in primary care.[419] These changes, which replace the GP Management Plan and Team Care Arrangements with a single, simplified GP Chronic Condition Management Plan, and equalise fees to encourage plan reviews, are a positive step.[420] These reforms support the findings of the MBS Review Taskforce to streamline arrangements and promote continuity of care.[421]

We also acknowledge recent government measures aimed at improving quality, such as $98 million for rebates on longer doctor consultations for people with chronic conditions and $48 million for wound care for patients with diabetes.[422]

We firmly believe care and funding models that prioritise quality over quantity in primary and tertiary care will have positive outcomes. Governments and providers should prioritise quality over quantity of services in government funding models, including the move to blended or capitated funding for service provision in primary and tertiary care. Rigid policy based on inputs, such as care minutes can stifle innovation and hinders the development of alternative models of care. A shift to robust quality and outcomes-based funding and regulation is needed across the health and care system.

We recognise the Australian Government's *Strengthening Primary Care* agenda. The recent *Unleashing the Potential of our Health Workforce Scope of Practice Review – Final Report* recommended changes to primary care funding models through blended funding models, with up to 40 per cent of funding at risk, to promote these

outcomes.[423] These reforms to primary care will allow more allied healthcare professionals to be embedded into general practice is welcome.

The current fee-for-service model often incentivises a high volume of services rather than efficient, preventative care. A move to capitated funding is another option, where providers receive a fixed amount per consumer regardless of how many services they use. This would encourage a greater focus on efficiency and preventative health.

EXAMPLE:

- **Funding:** Ramsay Health Care delivers mental health services to its patients in South Australia via a capitated model. Data indicates that the growth in funding needs through a capitated model is significantly lower than with activity-based funding.

Other future payment models should consider penalties for avoidable hospital readmissions, high infection control rates, and deviations of clinical care guidelines.

Action 33

Governments and providers should prioritise quality over quantity of services in government funding models, including the move to blended or capitated funding for service provision in primary and tertiary care.

7.2.9 Out-of-pocket expenses

Out-of-pocket expenses are a key reason many Australians avoid accessing certain services. These costs are not capped by the government and vary significantly depending on the specialist, procedure and location. In recent years, out-of-pocket expenses have been a primary reason for deferred healthcare, despite arguments both for and against their existence.[424]

We encourage greater price transparency for consumers. In 2022, the Medical Costs Finder was released to help Australians understand costs for GPs and specialists, but participation by specialists has been voluntary and uptake limited.[425] We welcome the government's recent announcement to make the Medical Costs Finder mandatory for specialists and insurers to increase transparency.[426]

The Australian Government may wish to consider other mechanisms to address out-of-pocket expenses. Consideration may also be given to alternative models of care that give Australians access to services.

Out-of-pocket expenses differ across Australia based on location, speciality and service type. In the March 2025 quarter, the average out-of-pocket payment for a hospital episode and medical services increased by 10.4 per cent to $470.80 and by 6.6 per cent to $270.81, respectively, compared to the same quarter for the previous year.[427]

In 2023, the average out-of-pocket cost for a non-bulk-billed GP attendance was $43.[428] These costs remain consistently high for those aged 16-64, while the 65-and-over cohort pays the least.

Medical specialists are known to routinely charge significant out-of-pocket expenses. This opacity and upward trend in costs are concerning. Consumers are more likely to pay for specialist and obstetric services, which have the highest out-of-pocket costs per service.[429] With increasing rates of chronic conditions and comorbidities, future reform must consider alternative models of care that give Australians access to services when they need them.

Action 34

The Australian Government may wish to consider other mechanisms to address out-of-pocket expenses. Consideration may also be given to alternative models of care that give Australians access to services.

7.2.10 Genomics / life insurance

Genomic testing, which is used to diagnose genetic conditions, assess disease risk, and guide treatment, is a game-changer. We welcome the government's commitment to establish Genomics Australia from 1 July 2025 to provide leadership and coordination for the nation to benefit from genomic research.[430] We also recognise and support the *National Health Genomics Policy Framework* being updated, which provides a national approach to embedding genomics into the health system.[431]

The BCA welcomes the Australian Government's 2024 announcement to ban the use of adverse

genetic testing results in life insurance.[432] We recognise the Australian Government continues to undertake further consultations but understand there is broad support from within the insurance industry to implement this policy change. As such, the Australian Government should introduce this legislation to parliament as a priority.

Australians should be able to understand their health and care risks without risk of being discriminated against by insurers based on their genomic test findings. Enabling Australians to test will allow them to manage their health conditions accordingly. This will help manage costs in the future. We also recognise new clinical services such as genetic testing for childhood hearing loss will receive $118.2 million over five years.[433]

Action 35

The Australian Government should introduce legislation to parliament as a priority to ban the use of adverse genetic testing results in life insurance. This will prevent lifetime insurers to discriminate against an individual based on their genomic testing findings.

7.2.11 Mental health

In total, mental illness, on a conservative basis, is costing Australia about $200-220 billion per year.[434]

Mental health is everyone's business, and we all have a role to play. Australia needs a productive workforce to lift living standards, and mental health directly impacts people's ability to be productive.

The PC found that reforming the mental health system would produce considerable benefits, including $18 billion in quality-of-life gains and $1.3 billion from increased economic participation.[435] By focusing on priority reform areas, 90 per cent of these benefits could be achieved.[436] This would require expenditure of up to $2.4 billion per year and could generate annual savings of up to $1.2 billion.[437]

7.2.11.1 National Centre for Workplace Mental Health and Wellbeing

Recent evidence suggests Australians are experiencing higher rates of burnout, exhaustion and cognitive impairment compared to the global average.[438] This is estimated to cost between $39 billion and $70 billion in annual direct and indirect costs.[439] In NSW alone, psychosocial injury claims have increased by 39 per cent in the past year.[440]

To address mentally healthy workplaces, a consortium is proposing to establish a National Centre for Workplace Mental Health and Wellbeing.[441] This Centre would address the urgent need for coordinated action and innovation to improve workplace mental health and wellbeing, productivity, and the growing psychosocial safety challenges impacting all working Australians.[442] We suggest governments work with industry, unions and research providers to create this Centre and support these tripartite initiatives. This national approach will unlock expertise, pool resources and drive industry-led research translation and the implementation of solutions.

In 2019-20, the Australian Government provided $11.5 million over four years for the National Workplace Initiative to provide a nationally consistent approach to workplace mental health.[443] This is another tripartite initiative which was initiated by the Mentally Healthy Workplace Alliance.[444] We suggest the Australian Government provide responsibility for the National Workplace Initiative to the proposed Centre. This will enable a national and consistent approach to supporting mentally healthy workplaces in Australia.

Action 36

Governments should work with industry, unions and research providers to create a National Centre for Workplace Mental Health and Wellbeing to unlock expertise, pool resources and drive the implementation of solutions.

Action 37

The Australian Government should provide responsibility for the National Workplace Initiative to the proposed National Centre for Workplace Mental Health and Wellbeing.

7.2.11.2 National Mental Health Commission

Established in 2012, the National Mental Health Commission provides advice to improve Australia's mental health and suicide prevention system.[445] Despite its efforts, the *National Report Card 2023* shows that a substantial number of Australians are experiencing mental health concerns, and the system continues to struggle to meet demand.[446] Between 2020-22, it is estimated one in five Australians had a mental health disorder.[447]

Despite significant government efforts, little progress has been made. Given the ongoing governance reforms of the National Mental Health Commission, we propose that the Australian Government should its roles and responsibilities to the Australian Centre for Disease Control. As mental health is a chronic condition, it is better suited to be managed by this body. Alternatively, the government should consider re-formalising the National Mental Health Commission as a separate entity, to the Department of Health, Disability and Ageing.

All stakeholders will need to work effectively together to ensure mental health service integration across the health and care system. The responsible body could lead this work.

Action 38

The Australian Government should transfer the roles and responsibilities of the National Mental Health Commission to the Australian Centre for Disease Control, as mental health is a chronic condition. Alternatively, the government should consider re-formalising the National Mental Health Commission as a separate entity to the Department of Health, Disability and Ageing.

7.2.11.3 Early intervention

Evidence shows that early intervention is key to addressing an individual's mental health. We recognise the Australian Government's commitment to launching a new national digital health service, which is expected to help 150,000 Australians each year before their distress becomes severe.[448] The Australian Government will need to ensure the new digital services reduces fragmentation within the mental health system.

While we support initiatives that use technology, the evidence from the UK indicates that they may not always meet their objectives. It is also unclear how this service will interact with existing online service providers including Beyond Blue, Lifeline and Head2Health. A workforce will also be needed to provide the services.

We have suggested the Australian Government undertake a review of the *Private Health Insurance Act 2007* (Cth). As part of this review, the government should consider whether legislative barriers should be removed to allow private health insurers to fund hospital-substitute care and expand their ability to fund out-of-hospital care, particularly in mental health.

Action 39

The Australian Government will need to ensure the new national digital health initiative reduces fragmentation within the mental health system to ensure Australians can access the services they require.

Action 40

The Australian Government should consider whether there are legislative barriers under the *Private Health Insurance Act 2007* (Cth) which should be removed to allow private health insurers to fund hospital-substitute care and expand their ability to fund out-of-hospital care, particularly in mental health.

7.2.11.4 Intervention – acute mental healthcare

We previously noted the significant costs associated with high acuity and ongoing mental health services. Broad reform will need to consider both the public and private sectors.

While we need to focus on prevention and early intervention, we must not overlook acute care. Recent media coverage indicates that the Australian mental health system is on the brink of collapse, with a dispute involving psychiatrists in the NSW public hospital serving as a case in point.[449]

Despite the findings of the *Contributing Lives, Thriving Communities – Review,* our system remains complex and fragmented.[450] The PC made similar findings in 2020.[451]

We recognise the Australian Government's announcements for 61 Medicare Mental Health Centres to provide immediate care; however, this is largely a rebranding of existing 'Head to Health' centres.[452]

As such, we encourage the Australian Government to expand the role of primary care, including general practices and mental health nurses, through blended funding models. Rather than creating additional points of contact, such as Medicare Mental Health Clinics and Primary Health Networks, a more collaborative effort is needed to make the consumer journey less fragmented and to lift mental health outcomes.

Action 41

The Australian Government should expand the role of primary care, including general practices and mental health nurses, through blended funding models to provide accessible mental health services for consumers.

7.2.11.5 Incentives – the 'missing middle'

Our federated system, with both public and private providers, creates duplication and fragmentation. A dysfunctional funding approach leads to poor incentives for providers and increased costs for consumers and taxpayers. The right incentives are needed to ensure Australians can access higher-intensity services.

Governments must liaise with the private sector on service delivery, as the private hospital system treats a relative portion of mental health patients. The Australian Government should consider amending the rules to allow a patient to be placed into the care of a psychologist or appropriate medical team. This would allow private psychiatrists to deliver care to more patients.

In the private setting, patients do not receive community services after a discharge, unlike in the public setting. Private psychiatrists are also responsible for managing their patients, but with an ongoing shortage of psychiatrists and many books closed, many Australians are finding it much harder to access care. Psychiatrists increasingly prefer to offer outpatient services given the financial incentives and limited on-call requirements.

The community remains concerned about reduced access to psychology services, particularly for more complex presentations. The MBS must incentivise private psychology practices to take patients who have been discharged from public and private facilities. These changes will improve current practices and address unused capacity across both sectors.

Action 42

The Australian Government should examine expanding MBS incentives to help Australians to access private mental health services.

7.2.12 Regional, rural and remote health

Seven million people live outside Australia's metropolitan areas, with a greater proportion of them being older than those in cities.[453] Those in regional, rural and remote communities face lower life expectancy, higher levels of disease and hospitalisation, and poorer access to services.[454] Additional challenges include socio-economic and occupational risks, as well as limited infrastructure and increased travel distances and costs. New models of care must be allowed to innovate in this space.

The health risks increase with the remoteness of a person's location, and the availability of services is directly linked to their use.[455]

The following statistics highlight the disparities between remote and metropolitan areas:[456]

- Mortality: The mortality rate is 1.1 times as high in regional areas, 1.2 times as high in remote areas, and 1.5 times as high in very remote areas.
- Preventative hospitalisation: This is slightly higher in inner-regional and outer-regional areas and 2-3 times as high for people living in remote and very remote areas.
- Hospitalisation: The hospitalisation rate is 1.3 times the rate in remote areas and almost twice the rate in very remote areas.

Screening rates for bowel, breast and cervical cancer are also lower for people in rural and remote areas. These rates can be improved through better access, early intervention and preventative measures.

The Department of Health, Disability and Ageing use the Modified Monash Model (MMM) to target

health workforce programs, with areas from MM2 to MM7 considered rural or remote. The distribution of the clinical workforce decreases with remoteness, and the number of specialists is highest in metropolitan areas.[457]

Several funding models are being trialled, and it is essential to continue exploring these with a focus on improving health outcomes and equitable access. Targeted investments and programs, including sending specialist teams to remote areas, are critical. The Royal Flying Doctor Service plays a vital role in providing care to some of the most remote parts of Australia.

Existing models often fail to evenly distribute healthcare workers or significantly improve health outcomes in remote communities. Alternative incentives and funding models must be considered to better support under-served areas. A greater uptake of "hub and spoke" models, particularly for preventative services, may be more effective in addressing the needs of a dispersed population.

Action 43

Incentivise the provision of health and care services in difficult-to-service areas, with a focus on evidence-based practices, training an appropriate workforce and the utilisation of telehealth.

Action 44

Provide digital infrastructure, such as faster internet connections and telehealth capabilities to enable greater access to specialist services without the need to travel, noting this will require broader government support.

Action 45

Enable new funding models that support the flexible movement of health and care workers to provide better access to care in remote, rural and regional areas. This could include specific regional hub and spoke models to deliver necessary services.

7.2.13 Indigenous health

Significant efforts have been made to close the gap between Indigenous and non-Indigenous outcomes. While there have been some successes, much more needs to be done to remove disparities.[458] Indigenous health is complex because First Nations people are not a single homogenous group but comprise many groups within their own cultures and traditions.[459]

The latest PC's Closing the Gap annual report indicates that we are not on track to meet several health targets by 2031.[460] For instance, while life expectancy has improved, achieving a zero-life expectancy gap by 2031 is unlikely.[461] In 2020-22, the gap was 8.8 years for Indigenous males 8.1 years for Indigenous females.[462]

The First Nations population has a larger proportion of people aged 29 and under (refer to figure 27). As of June 2021, one-third of First Nations people were under 15, compared to 17 per cent for the non-Indigenous population.[463] This indicates that health initiatives should be designed to target a younger demographic.

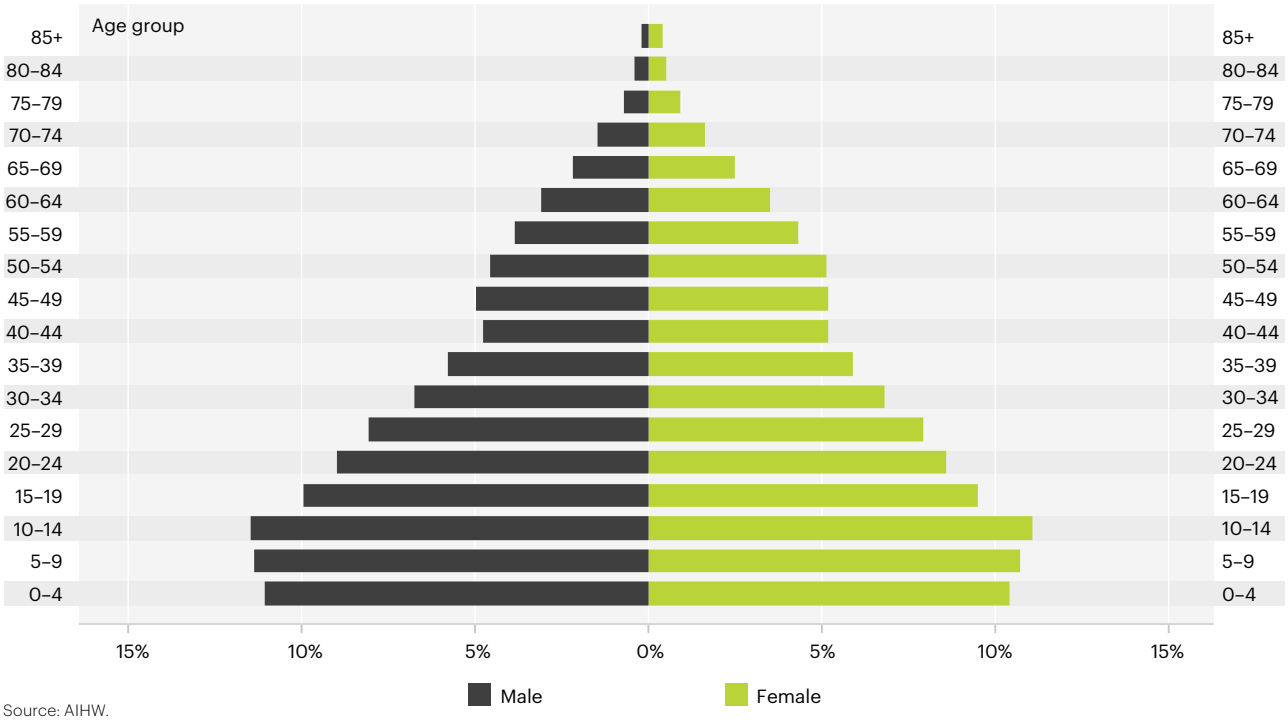
Understanding where services are needed is crucial given our workforce shortages and the large dispersion of the population. More First Nations people live in major cities (41 per cent) and inner and outer regional areas (44 per cent) than in remote and very remote areas (15 per cent).[464]

However, the proportion of Indigenous people relative to the total population increases with remoteness, rising to 30 per cent in remote and very remote areas.[465] A concerted effort is needed to ensure rural and remote areas receive adequate services, particularly in preventative health and care.

The leading causes of death for Indigenous people vary by age, from conditions in the perinatal period for infants, to self-harm in young adults aged 15-39, and ischemic heart disease for those aged 40-74.[466] Concerningly, there has been little improvement in associated risk factors, including smoking, alcohol consumption, obesity and substance abuse.[467]

We must focus not only on access but on better use of health services to improve outcomes. Services need to be culturally safe and community integrated.[468] Appropriately resourced Aboriginal Community Controlled Health Organisations (ACCHOs), which deliver holistic care, are a prudent approach to improving access to

Figure 27: First Nations population by age and sex, 30 June 2021



Source: AIHW.

culturally safe services. For example, ongoing access to antenatal services will help ensure babies are healthy and strong, and support birthing on country.

The target for a significant reduction in Indigenous suicides is off track. The age-adjusted suicide rate has risen, and it remains the leading cause of death for those aged 15 to 39.[469] In 2023, suicide rates were 3.5 times higher for males than females.[470]

Targeted investment by government, including public-private partnerships, will help address the ongoing gap in health outcomes for Indigenous Australians.

Action 46

Make targeted investments and co-design with Indigenous Australians to address Closing the Gap goals. This should include greater uptake of chronic disease care plans and improved access to specialist services.

Action 47

Enable Aboriginal Community Controlled Health Organisations (ACCHOs) to deliver a wider range of services and provide additional funding for education.

7.3 Innovation and technology

Recommendation 3.

Invest in early intervention, research, innovation and prevention to cultivate a healthier and more productive nation.

This focus will enable people to live healthy lives while reducing the financial burden on the health and care economy.

A range of innovations, developed through research – including digital, pharmaceutical, and technology – can mitigate many systemic challenges by improving productivity, reducing demand for resource-intensive services, enhancing quality and safety, and making care more convenient.[471] We know many of these innovations go hand in hand, with research supporting the advancement of new technology and medicines that can boost efficiency and quality of care, contributing to us living longer.[472]

Better coordination and investment can improve the quality and safety of care and increase productivity.[473] It will ensure taxpayers and consumers get better value and outcomes for every dollar spent.[474] Australia has some of the best health research in the world, with breakthroughs such as penicillin, the bionic ear, greyscale ultrasound imaging, spray-on skin, and the cervical cancer vaccine.[475] It is a proud track record that we should seek to build on.

7.3.1 Productivity

Productivity is about change that adds value.[476] We recognise the Economic Reform Roundtable which discussed key issues including resilience, productivity and budget sustainability, and tax reform. As progress continues, we would encourage governments to consider the BCA's *The big five questions* and recommendations from its *Australia's flagging productivity and international competitiveness* report to increase productivity across the economy, including the health and care sectors.[477]

We also recognise the recent productivity roundtable held by the Minister for Health, Disability and Ageing. It is crucial all governments and the PC take a whole-of-systems perspective, examining how primary care, secondary care, tertiary care, aged care and the NDIS interact.

Many Australians enjoy an extraordinary quality of life, but this is at risk unless we address productivity in the health and care economy, particularly the non-market sector, where lifting productivity is challenging.[478] PC Chair Danielle Wood has highlighted the ongoing difficulty of improving productivity in labour-intensive industries, despite significant government investment.[479]

We recognise that productivity grew by 3 per cent a year (quality-adjusted) in the treatment of five specific diseases between 2011-12 and 2017-18, meaning health outcomes improved more than the money spent.[480] However, an ageing population and a growing government footprint mean an expanding health and care sector.[481] Introducing new models of care and technology into existing structures can be challenging but is necessary to do.[482]

We support the Australian Government's focus on productivity and the tasking of the PC with the five key pillar inquiries, including the health and care economy.[483] We welcome the PC's interim report into *Delivering quality care more efficiently* in the lead up to the Economic Reform Roundtable, and suggest all governments ensure the interim findings are considered as part of the current NHRA and NDIS negotiations.[484]

However, we note that there are already a vast range of reports delivered by the PC to improve productivity, including chronic conditions, competition and informed user choice, digital health, efficiency in health, mental health, NDIS and older Australians.[485] As such, we suggest the Australian Government also continue to consider

these previous reports and recommendations including digital health and mental health.

It is clear there are a range of actions beyond the current interim report which could be implemented to improve productivity. We also encourage the PC to consider existing health and care economy reports and associated recommendations to incorporate into the final report, particularly the use of technology to lift productivity and alleviate workforce pressures. This is crucial to ensure the Australian Government is provided a clear path forward to address the challenges faced by the health and care economy.

Action 48

Governments should consider the BCA's *The big five questions* and recommendations from its *Australia's flagging productivity and international competitiveness* report to increase productivity across the economy, including the health and care sectors.

Action 49

All governments should ensure the findings from the Productivity Commission's *Delivering quality care more efficiently* interim report are considered as part of the current National Health Reform Agreement and National Disability Insurance Scheme negotiations.

Action 50

The Australian Government should consider the Productivity Commission's previous reports and recommendations on the health and care economy, including digital health and mental health.

Action 51

The Productivity Commission should consider existing health and care economy reports and associated recommendations to incorporate into the final report, such as digital health.

7.3.2 Preventative health

The Australian Government suggests every dollar invested in preventative health saves about $14.30 in healthcare and other costs.[486]

Our current system places more emphasis on the acute setting rather than on preventative and community health.[487] The *National Preventative Health Strategy 2021-2030* is supported by associated strategies for tobacco, drugs, and other health issues.[488] Many initiatives are effective, particularly our world-leading cancer screening programs such as bowel cancer testing.[489]

However, we need to reorient the system to tackle major burdens of disease by better coordinating preventative health initiatives and increasing total investment.[490] Fragmented funding, financing and policy responsibilities weaken incentives to invest.[491]

We recognise Australians will still become unwell and require services – that is a given. But we need to move from fixing problems to preventing them or at least making early intervention available before they become chronic. The PC has previously estimated the prevalence of chronic conditions comes at a substantial cost of approximately $38 billion annually to provide services to people with chronic conditions.[492]

7.3.2.1 Australian Centre for Disease Control

Australia must take a coordinated and committed approach to long-term preventative health. While we have excellent programs, there is limited overarching coordination to ensure they are well-targeted and address priority areas that will save lives and money in the long-term. This is crucial to ensure the population remains healthy and productive.

International examples demonstrate the influential role national organisations can play in leading a nations effort to combat infectious and preventative diseases. Many of these organisations, which came to the fore during COVID-19 have focused on tackling major chronic diseases. These organisations demonstrate how international collaboration and investment in disease prevention can lead to improvements in global health security and public health outcomes.

EXAMPLE:

- **Africa:** The Africa Centres for Disease Control and Prevention supports public health initiatives and strengthens the capacity of public health institutions to detect, prevent, control and respond quickly and effectively to disease threats.[493]
- **European Union:** The European Centre for Disease Prevention and Control strengthens Europe's defences against infectious diseases, including surveillance, outbreak preparedness, scientific advice, prevention and public health training and communication.[494]

In 2008, the Council of Australian Governments identified the need for such an agency, which was further supported by subsequent reports, including the National Preventative Health Taskforce and the National Health and Hospitals Reform Commission.[495] Established in 2011, the Australian National Preventative Health Agency ceased operations in 2014, with its key functions transferred to the Department of Health.[496]

A national approach is again needed to drive preventative health policies and programs given the vast number of national and state-based strategies and initiatives.[497] The *COVID-19 Response Inquiry Report* also recommended Health Ministers coordinate a 'COVID Catch-Up' Strategy to address critical gaps in health recovery, including greater investment in mental health support due to a decline in the delivery of key health prevention measures.[498] Some state governments are leading the way.

EXAMPLE:

- **Queensland:** In 2019, the Queensland Government established Health and Wellbeing Queensland to improve the health and wellbeing of all Queenslanders and reduce health inequities, with a focus on areas like healthy weight, strengthening prevention, remote food security, wellbeing and health equity.[499]
- **South Australia:** In 2024, the South Australian Government established Preventative Health SA to improve the health and wellbeing of its citizens, with a focus on areas like obesity, tobacco control, mental health and the determinants of health.[500]

Australian Institute of Health and Welfare (AIHW) data demonstrates why it is necessary to re-establish a national approach. The National Preventive Health Monitoring Dashboard highlights that very little improvement has been made in key areas since 2018.[501] For instance, there has been minimal change in the number of years lived in full health and public health expenditure remains at 2.3 per cent of total health expenditure.[502]

We recognise the Australian Government's ongoing commitment to establish the ACDC.[503] We urge the Australian Government to expedite the process to ensure Australia is prepared for future pandemics, addressing findings from the *COVID-19 Response Inquiry Report*.[504] This needs to be addressed sooner rather than later.

International examples show that national organisations can be influential in leading a nation's effort to not only combat infectious but also preventative diseases. Therefore, we propose that, the Australian Government should expand the role of the Australian Centre for Disease Control (ACDC) to include prevention. This would follow a similar approach to Africa and the European Union.

EXAMPLE:

- **European Union:** In 2022, the European Centre for Disease Prevention and Control's mandate was expanded to include a renewed and expanded commitment to prevention, including social and behavioural sciences.[505]

We welcome the focus by the PC in its interim report into *Delivering quality care more efficiently,* which highlights the importance of preventative actions. This includes the need for greater efforts across all governments. With National Cabinet buy-in, the ACDC could play a more effective national role in coordinating preventative policies and programs. As we learned from the COVID-19

response, the best outcomes are achieved when federal, state and territory health authorities work together, sharing data and coordinating their efforts.[506]

An additional focus on chronic disease prevention would complement the ACDC's work on communicable disease and existing programs like immunisation.[507] Consideration should also be given to the role of the Australian Prevention Partnership Centre which is already funded by various governments and not-for-profit partners to build an effective, efficient and equitable system for the prevention of chronic disease.[508]

The *Mid-Term Review of the NHRA* also called for a renewed focus on prevention.[509] National Cabinet needs to ensure that prevention activities are a priority, set out in the updated NHRA, and complement the National Preventative Health Strategy, and the work of the ACDC. The *NSW Special Commission into Healthcare Funding* also highlights the need for a greater emphasis on prevention.[510]

Other areas for consideration include the oversight of the Preventative and Public Health Research Initiative and the development of a preventative healthcare portal for consumers and professionals to easily access resources.[511]

Action 52

The Australian Government should expedite the establishment of the Australian Centre for Disease Control to address the findings of the *COVID-19 Response Inquiry Report*.

Action 53

The Australian Government should expand the role of the Australian Centre for Disease Control to include prevention. This would follow a similar approach to international comparisons. Consideration should also be given to the Australian Prevention Partnership Centre which is already funded by various governments and not-for-profit partners.

Action 54

National Cabinet must ensure prevention activities are a priority and set out in the updated National Health Reform Agreement, complementing the National Preventative Health Strategy, and the work of the Australian Centre for Disease Control.

7.3.2.2 Preventative healthcare spend and investment

In 2023, preventative care accounted for only 3 per cent of health expenditure, a stark contrast to Indonesia's 18 per cent and the OECD average of 5 per cent (refer to figure 28).[512] The *National Preventative Health Strategy* has set a target of 5 per cent of total health expenditure by 2030.[513] However, greater action and investment are needed. The PC estimates Australia's GDP could increase by $4 billion per year if the health of people in fair or poor health was improved.[514] Greater and more timely adoption of cost effective preventative measures would help reduce our sizeable risk factors and enable our healthcare sector to do more with less.[515]

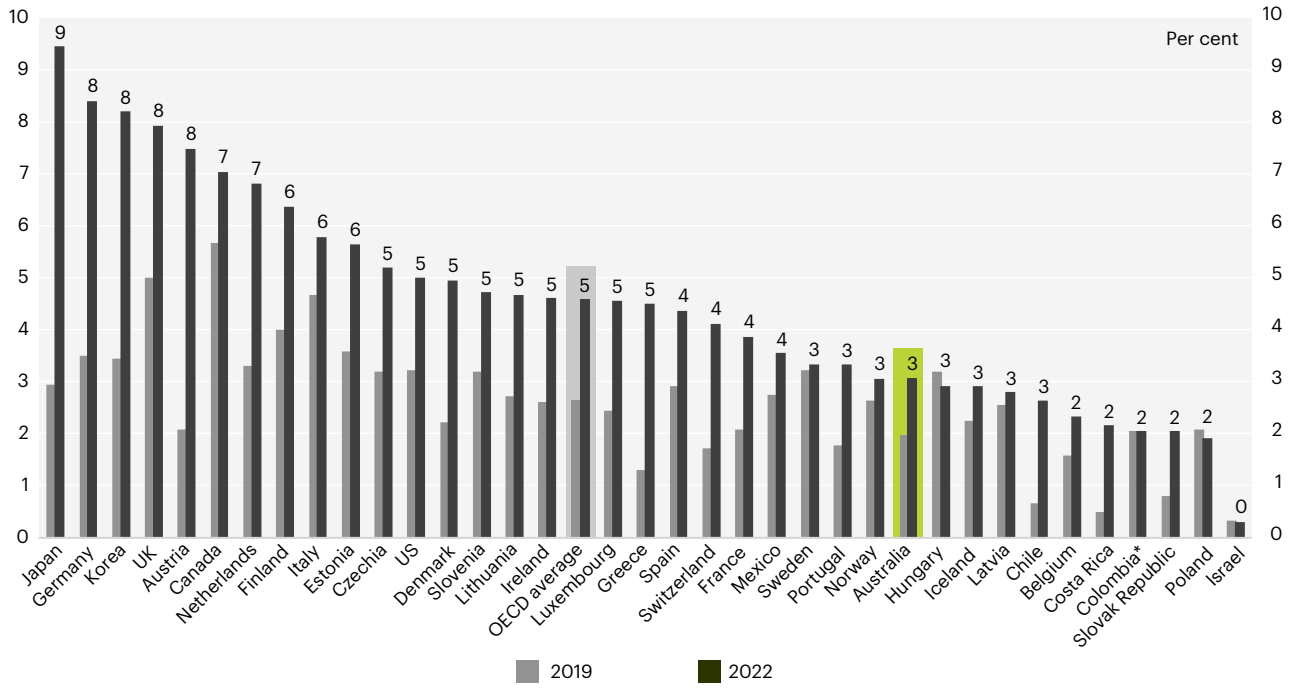
Given how far behind Australia is compared to other OECD countries, we suggest all governments aim to increase health expenditure for preventative health measures to five per cent by 2030. These measures should be cost effective, and evidence based. This will bring Australia in line with the current OECD average spend but should not be seen as the final goal.

The *NSW Special Commission into Healthcare Funding* supports this, stating that preventative health should be a long-term, whole-of-government priority.[516] Significant investment is needed to put our broader health and care system on a more sustainable trajectory.

We recognise and support the PC's interim report into *Delivering quality care more efficiently* which calls for the development of a national framework to guide government investment in prevention, improve outcomes for Australians and reduce demand on services.[517] We also suggest the national framework include an evaluation framework. This will support the implementation of the *National Preventative Health Strategy*.[518]

The framework should provide the key foundations and measures to ensure the long-term benefits

Figure 28: Share of spending on prevention in current health expenditure, 2019 and 2021 (or nearest year)



Note: the latest and only data available for Columbia is for 2017

Source: OECD Data Explorer, *Health Statistics*.

of preventative measures are recognised and help address the issues regarding government processes and barriers. Previous studies highlight there are a wide range of methods used to evaluate initiatives, with many initiatives lacking the evidence to demonstrate cost effectiveness and positive outcomes.[519]

While we acknowledge the PC's proposal to establish an Independent Prevention Framework Advisory Board to assess and provide expert advice on requests for funding, a more holistic and sustained approach is warranted.[520] This is one option for putting discipline into funding processes. However, caution is needed to ensure it does not create a new bureaucratic process and barrier to innovation and long-term investment.

Consideration may be given to the establishment of a National Prevention Investment Fund like the National Productivity Fund which would allow governments to propose programs that draw from these funds.[521] Investment in preventative measures is cheaper than the acute setting. Hospitals are expensive to run. Furthermore, alternative models of care, including increased investment in targeted measures, will help keep Australians healthy, reduce hospitalisations and make the best use of our health and care professionals.[522] This could also lead to an increase in productivity across the broader economy.[523]

Governments should target investment in preventative measures with a particular focus on leading causes of disease, including mental health, cardiovascular disease and obesity. Obesity is a significant challenge for Australia, with 30 per cent of Australians being obese, above the OECD average of 26 per cent (refer to figure 29).[524]

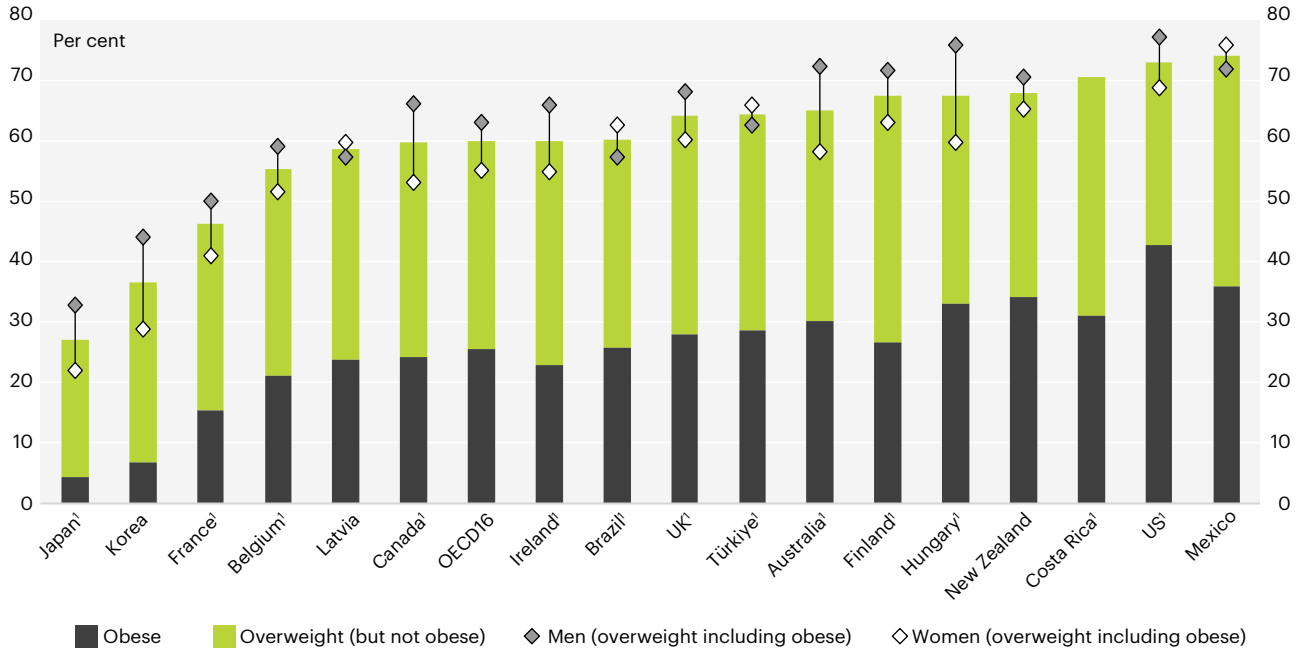
EXAMPLE:

- **Obesity:** The *Health at a Glance 2023* report highlights that obesity is a common challenge for most countries:

...with 54 per cent of adults being overweight or obese. It also notes that only 15 per cent of adults consume five or more portions of fruit and vegetables per day, and only 40 per cent performed at least 150 minutes of moderate to vigorous physical activity per week.[525]

Australia should also be recognised for its concerted efforts and world leading approach to tackle specific issues like smoking, with daily smoking rates falling from 24.3 per cent in 1991

Figure 29: Measured overweight and obesity rates among adults, by sex, 2021 (or nearest year)



Source: OECD Data Explorer, *Health Statistics*.

to 8.3 per cent in 2022-23 (refer to figure 27).[526] However, we recognise excessive excise may lead to broader issues, including the rise in illegal trade.[527] Tobacco remains the second-highest risk factor for the development of disease, responsible for 7.6 per cent of the total burden of disease and injury.[528]

The BCA recognises the Australian Government's efforts to combat the increasing risk of vapes and e-cigarettes.[529] We support appropriate regulation to address these risks, particularly for younger generations.

Detection and prevention are key. Australia has a range of national screening programs for bowel, breast and cervical cancer, as well as for bloodspot and hearing.[530] We acknowledge the Australian Government's decision to launch a lung screening program and expand eligibility for bowel cancer testing to 45-year-olds.[531]

Australia is also known to have some of the highest rates of cancer globally, but with generally positive outcomes.[532] Skin cancer is one of the biggest draws on the health system, but since 1980-81, the 'Slip, Slop, Slap' campaign has played an important role in teaching Australians to be sun smart and reduce ultraviolet exposure.[533]

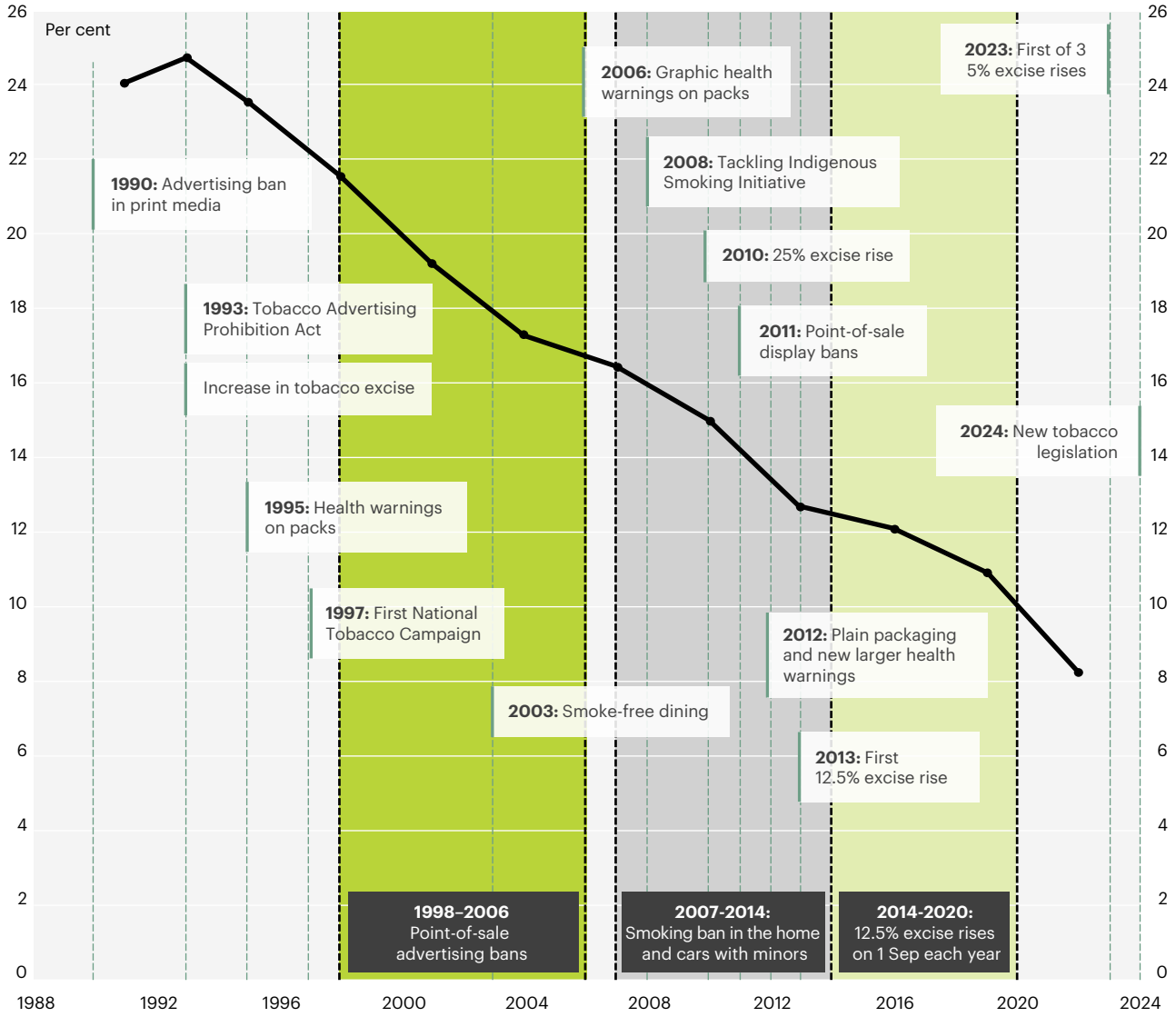
However, we have recently seen an increase in risky behaviour and a lack of concern for the consequences, particularly among younger people, as highlighted by trends like #sunburntanlines on platforms such as TikTok.[534] The Australian Government's $15 million commitment to a national skin cancer prevention campaign is a step in the right direction.[535] This campaign should reinforce the importance of preventing skin cancer in the Australian psyche.

The PC has previously outlined a range of instruments which can be used to promote preventative health including:[536]

- Price signals to influence consumer behaviour, such as taxes on alcohol and cigarettes.
- Regulation to discourage undesirable behaviours, such as cigarette packaging.
- Regulations to improve information disclosure, such as food labelling requirements.
- Information on moral suasion to influence behaviour, such as campaigns.
- Clinical interventions, such as screening for a particular condition.

We recommend governments consider a range of specific preventative health initiatives to improve the health of the population, such as awareness

Figure 30: People aged 14 and over who smoke daily and key tobacco control measures in Australia, 1990 to 2022-2023 (per cent)



Source: Commonwealth of Australia, Australian Institute of Health and Welfare. (2025). *Alcohol, tobacco & other drugs in Australia.*

campaigns, education and training, and early intervention. Governments should focus on priority populations such as First Nations people, those with a lower socioeconomic status, and people with disability, to have the greatest impact.

Other initiatives could include vaccinations programs, screening and early detection, and mental health support.

Universities are a key part of educating and training our future health and care workforce. As such, governments should work with universities to develop and expand low-cost, student-led preventative health and care service models on campus.

EXAMPLE:

- **Optometry:** At UNSW, the Optometry Clinic provides free comprehensive eye checks performed by senior optometry students under the supervision of qualified optometrists. The clinic focuses on providing quality eye care and professional services to consumers on a range of topics from eye health to occupational eye protection.[537]

These models could be open to staff, students and the public to access early intervention and preventative services while supporting health and care students to gain practical experience to become qualified health and care workers. Appropriate clinical governance and supervision will be necessary. Given the range of university campus locations, these initiatives could have a positive impact on supporting consumers to prevent and/or manage health conditions.

Action 55

All governments should commit to increasing health expenditure for preventative health measures to five per cent by 2030 as a first step to align with the OECD average. These measures should be cost effective and evidence based. Consideration may be given to the establishment of a National Prevention Investment Fund.

Action 56

The Australian Government should consider developing a preventative health framework to support the implementation of the *National Preventative Health Strategy*. This should also include an evaluation framework. This national framework would provide the key foundations and measures to ensure the long-term benefits of preventative measures are recognised.

Action 57

Governments should target investment in preventative measures with a particular focus on the leading cause of disease, including mental health, cardiovascular disease and obesity. These measures should be cost effective, and evidence based.

Action 58

Governments should consider a range of specific preventative health initiatives and measures to improve the health of the population, such as awareness campaigns, education and training, and early intervention

Governments should focus on priority populations such as First Nations people, those with lower socioeconomic status and people with disability to have greater impact.

Action 59

Governments should work with universities to develop and expand low-cost, student-led preventative health and care service models on campus. These models would provide access to early intervention and preventative services while supporting health and care students to gain experience to become qualified health and care workers.

7.3.2.3 Dementia, hearing loss and timely intervention

Dementia costs the global economy more than US$1.3 trillion annually and is projected to increase to US$2.8 trillion by 2030.[538] Several governments and influential international organisations have prioritised dementia action plans that includes a focus on prevention, including the United States' *National Plan to Address Alzheimer's Disease*, the World Health Organization *Global Action Plan* and *Australia's National Dementia Action Plan 2023-2034*.[539]

Dementia is the second leading cause of disease burden among Australians aged 65 and over, and the leading cause among older women.[540] In 2016, its total economic cost was estimated at $14.25 billion and is projected to rise to $36.8 billion by 2056, driven by growing demand for health and aged care services, and lost productivity.[541]

The 2024 *Lancet Commission for Dementia* identified 14 potentially modifiable risk factors that together could prevent or delay up to 45 per cent of dementia cases globally.[542] Among these, hearing loss is the single largest modifiable risk factor, accounting for an estimated 7 per of all potentially preventable dementia cases. In Australia, hearing loss affects one in three people over the age of 65 and is often underdiagnosed or undertreated, with fewer than 40 per cent of Australian adults with hearing loss receiving treatment.[543]

Studies consistently find that the risk of dementia increases with the severity of hearing loss; it doubles with mild hearing loss, triples with

moderate loss, and increases fivefold with severe loss.[544] There was also a 16 per cent increase in dementia risk associated with every 10-decibels worsening of hearing.[545] The link between hearing loss and dementia is thought to rise from both direct and indirect effects such as social isolation, depression, and neurodegeneration.[546]

Our primary care system can play a critical role in detecting early signs of hearing loss, with GPs being a frequent point of contact for older Australians. Despite its impact, hearing impairment is frequently overlooked in routine care – 85 per cent of older Australians have never discussed it with their GP, formal screening and associated protocols are uncommon, and less than 20 per cent of GPs are aware of treatment options like cochlear implants.[547] This gap delays timely intervention and increases dementia risk.[548]

We suggest the Australian Government implement routine hearing screening every 1-3 years for adults aged 50 and over, led by GPs and integrated into chronic disease assessments to improve hearing outcomes. This should be supported by clear referral pathways to audiology and hearing rehabilitation services. Nationally consistent cochlear implant referral criteria should also be embedded across both the public and private sectors.

Early diagnosis and intervention is recommended for hearing loss to improve quality of life and reduce the risk of dementia.[549] Although, cochlear implants are the gold standard for treating severe-to-profound hearing loss in adults, consumers typically wait an average of 12 years before receiving them.[550] Delays in treatment can lead to sensory deprivation, reducing the brain's ability to benefits from assistive devices.[551] These risks are critical for those with severe impairment, who face systemic barriers such as limited awareness and restrictive referral criteria – despite Cochlear implants being a proven, cost-effective solution.[552]

Despite clear benefits to quality of life and health savings, hearing rehabilitation is underused, with only one in two Australians using a hearing aid.[553] Furthermore, fewer than 8-10 per cent of Australians who are eligible for a cochlear implant receive one.[554] A major barrier is the lack of understanding of treatment options and care pathways among both consumers and health professionals.[555]

We also suggest governments increase public funding caps for cochlear implants to ensure early and timely access for older adults, helping to reduce waiting times, improve hearing outcomes, and lower dementia risk through early intervention.

Early intervention for hearing loss – Australia's leading modifiable risk factor for dementia – could significantly reduce long-term health and care costs. Economic modelling suggests a 5 per cent reduction in dementia incidence among Australians over the age of 65 could save up to AUD$120.4 billion by 2056.[556]

Action 60

The Australian Government should implement routine hearing screening every 1-3 years for adults aged 50 and over, led by GPs and integrated into chronic disease assessments to improve hearing outcomes. This should be supported by clear referral pathways to audiology and hearing rehabilitation services. Nationally consistent cochlear implant referral criteria should also be embedded across both the public and private sectors.

Action 61

Increase public funding caps for cochlear implants to ensure early and timely access for older adults, helping to reduce waiting times, improve hearing outcomes, and lower dementia risk through early intervention.

7.3.2.4 A whole-of-system approach

To ensure Australians live healthier and more productive lives, a broader whole-of-system approach and consideration of the social determinants of health are necessary. Evidence demonstrates that social determinants including education, employment, income, and housing play a significant role in an individual's health and care journey.[557]

Furthermore, tackling social determinants can significantly reduce adverse health and care outcomes.[558] Leading contributors to disease, such as obesity and alcohol use, may not be immediate problems, but in the long term, they can lead to chronic illnesses.[559]

The proposed preventative framework and amended internal government processes (which will be addressed later) should enable greater collaboration between Ministers. Governments should consider incentivising and improving processes that would allow for the identification of cross-portfolio issues and for initiatives to be brought forward by multiple Ministers.

Separately, we would caution the creation of a new intergovernmental agreement on preventative health between governments.[560] This should form part of the new NHRA as a dedicated schedule. We all have a role to play in the broader efforts to make Australia healthier by taking a whole-of-system approach and addressing determinants of health.

EXAMPLE:

- **Education:** The Minister for Health, Ageing and Disability could bring forward a joint proposal with the Minister for Early Childhood Education and the Minister Education to improve the health literacy of children and young adults. By improving an individual's health literacy (in the education portfolio), this could have a net positive impact on the health portfolio at a later stage as the individual is able to manage their health and wellbeing more proactively.

Action 62

Governments should consider incentivising and improving processes that would effectively allow for the identification of cross-portfolio issues and for initiatives to be brought forward by several Ministers. This would enable governments to tackle issues before they become health problems.

7.3.3 Innovation – Digital Systems and Interoperability

The OECD has estimated a potential return of $3 for every $1 invested in effective digital strategies, with the PC suggesting digital applications could reduce costs by more than $5 billion annually.[561]

The health and care system, which will likely remain labour intensive, must look to other ways of lifting productivity. Digital technology will be crucial to this transformation.

Australia's health and care system must leverage technology to improve the convenience, efficiency and precision of care, while protecting consumer privacy and safety.[562] Technology will be a critical enabler for workforce reform and automating, digitising and standardising processes to lift productivity.[563] It could also increase workforce satisfaction by allowing workers to focus on caring activities rather than administrative ones.[564]

Despite the proven benefits, the health and care economy continues to lag in digital systems investment compared other countries and industries.[565] While COVID-19 accelerated the implementation of some digital initiatives, such as telehealth and electronic prescribing, it also demonstrated what can be achieved quickly and efficiently when there is the will to do so.[566] We also acknowledge the ongoing work of the Department of Health, Disability and Ageing and the Australian Digital Health Agency to drive digital health and aged care transformation.

The consumer's health and care journey is rarely linear. Australians may move from a GP to a specialist, then to a public or private hospital, and potentially to a residential aged care facility. Each provider often relies on the consumer to carry relevant documentation, or receives it via fax, email or letter. This can lead to scans and tests being needlessly re-done because results have not been captured and shared.[567]

The PC's *Delivering quality care more efficiently* interim report notes governments must ensure that regulatory settings support innovation while managing its risks and reduce fragmentation in healthcare to foster innovation, improve care outcomes and generate savings.[568]

To address this, we suggest the Australian Government rename the Australian Digital Health Agency to the Australian Digital Health and Care Agency and expand its remit to oversee digital transformation across aged care and disability. This agency should work closely with state and territory government agencies to ensure a nationally coordinated approach. This would ensure a more holistic approach is taken and aligns with our broader recommendations for the health and care economy.

These digital measures will not supplant the workforce but will expand the scale and reach of services, benefiting consumers, particularly those who have had limited access to care.[569] There is much more to do, especially with advances in AI for diagnostics and remote monitoring, and the use of wearable devices for preventative health programs.[570]

Action 63

The Australian Government should rename the Australian Digital Health Agency to the Australian Digital Health and Care Agency with an expanded remit to oversee digital transformation across aged care and disability. This will ensure a more holistic approach to digital transformation is considered.

7.3.3.1 Interoperability and sharing of information

Interoperability remains a challenge across the health and care system with digital solutions using different standards.[571] Getting the regulatory and technological architecture right is critical for system transformation and greater care integration.

The BCA acknowledges the work of the Australian Digital Health Agency and its partners driving the consistent adoption of digital health standards across Australia.[572] The Sparked AU FHIR Accelerator is a key initiative in this effort, aiming to deliver a core set of Fast Healthcare Interoperability Resources (FHIR) standard for use in Australia over three years, supporting the *National Healthcare Interoperability Plan 2023-2028*.[573]

We recognise the Australian Government's investment of $15.7 million over two years and a further $1.9 million in 2024-25 to progress these national health priorities.[574] These standards must be implemented before further significant investments are made in digital solutions that otherwise risk becoming obsolete.

The PC has previously warned delaying reform will compound costs and the lost opportunities of not releasing or sharing information.[575] A clear plan is needed for how interoperability will operate across the entire health and care system, including what data will be captured. The goal should be national health and care standards that enable information to be easily shared across the consumer journey. This is crucial as sectors like aged care, and the NDIS increasingly deliver services, such as home care or diabetes management. All levels of government and the private sector must be consulted.

We suggest the Australian Government expand and mandate the *National Healthcare Interoperability Plan 2023-2028* and related standards to the entire health and care economy, encompassing aged care and disability. This would make it easier for consumers and professionals to access information, deliver better care and reflect the changing structure of the economy. This should be done in parallel with strong privacy considerations.

We also suggest that the Australian Government establish a public register of health and care software that can be integrated with My Health Record. This would help providers invest in interoperable systems and align with a previous PC recommendation.[576] Incentives for developers should also be considered.

By improving information sharing and investing in interoperable systems, we can enhance the consumer experience and make the care pathway more efficient. This would also incentivise the development of new, more consumer-centred technologies.

Action 64

The Australian Government should expand and mandate the *National Healthcare Interoperability Plan 2023-2028* and related standards to the entire health and care economy, including aged care and disability, in parallel with privacy considerations.

Action 65

The Australian Government should establish a public register of health and care software that can be integrated with My Health Record to help providers invest in interoperable systems. Incentives for developers should also be considered.

7.3.3.2 Health and care identifiers

The *Healthcare Identifiers Act 2010* (Cth) supports a national system for assigning unique 16-digit identifiers to individuals, healthcare providers and organisations.[577] The Australian Government

consulted in 2022 and 2023 on the Healthcare Identifiers Framework to explore potential legislative and policy changes to increase their use.[578]

We welcome the Australian Digital Health Agency's *National Healthcare Identifiers Roadmap 2023-2028*, which aims to use these identifiers as a tool to address the challenge of interoperability.[579] We suggest the Australian Government consider expanding and mandating this roadmap across the entire health and care system – including health, aged care and disability within both the public and private sectors.

With similar services being offered across these settings, it is important for all providers to understand a consumer's existing treatments or care plans. Sharing information can help avoid duplicative services and identify gaps in consumer care.[580]

Action 66

The Australian Government should consider expanding and mandating the *National Healthcare Identifiers Roadmap 2023-2028* across the health and care system for greater system interoperability – including health, aged care and disability within the public and private sectors.

7.3.3.3 Consumer Data

Technology will play a role in consumers managing their health and wellbeing. While clinical information is important and suitable for inclusion in My Health Record, there will also be other data that is complementary to consumers managing and engaging their health, such as insights into their movement and activity. This will increase with the uptake of technology. It will be important that consumers have control over their data.

All stakeholders should play an active role in enabling the settings to allow for the development and use of consumer technological solutions, subject to privacy and security standards. Suggested features should include end-to-end encryption and third-party app controls.[581] Many of these solutions will be preventative in nature supporting consumers to address potential health issues sooner rather than later.

EXAMPLE:

- **Data:** Apple's Health app and HealthKit makes it easy for consumers to access health and fitness information. It brings together over 150 different types of health data from Apple Watch, iPhone, iPad and authorised third-party apps and devices. The Health app was designed with four key privacy principles: data minimisation, on-device processing, transparency, control, and security – giving consumers control over their own health data.[582]

Action 67

All stakeholders should play an active role in enabling the settings to allow for the development and use of consumer technological solutions, subject to privacy and security standards. It will be important that consumers have control over their data.

7.3.3.4 Technology Investment

Better coordination and investment can improve the quality and safety of care and increase productivity.[583] While technology uptake can be expensive for both the public and private sectors, international examples show a strong return on investment in digital solutions. These examples also provide important learnings and potential models for Australia to consider.

EXAMPLE:

- **Canada:** Canada Health Infoway is a federally funded, not-for-profit organisation that provides funding and support to both public and private health and aged care providers to adopt and integrate digital health records.[584]
- **United States:** The US government allocated $27 billion to incentivise the adoption of electronic health records among hospital and private providers under the *Health Information Technology for Economic and Clinical Health Act 2009*, offering financial rewards for "meaningful use" of the technology.[585]

While digital technology is having an impact, there are still many opportunities to unlock benefits, particularly for productivity. Despite a $2 billion investment, health data remains fragmented.[586] Thus far, My Health Record has been a missed opportunity, failing to reach its full potential with limited use across the health and care system. The platform has struggled with outdated architecture, a poor user experience, privacy concerns, and a lack of useful health information.

Continued investment in, and a review of, regulatory barriers to using My Health Record and it's supporting architecture, is crucial to making it easier to access and share information. The ANAO estimated that it could take 10 years for the intended benefits to be realised.[587] A further fragmentation of the system has occurred with the establishment of a separate aged care portal, NDIS myplace portal, and Carer Gateway, all of which need to be interoperable.

We acknowledge the Australian Government's efforts to modernise My Health Record through improved sharing of pathology and diagnostic imaging information.[588] The PC found that the rollout of an electronic medical record across all public hospitals could save about $355 million annually by reducing duplicated pathology and imaging, which would also increase productivity.[589]

However, these changes do not address the need for broader interoperability with primary care, aged care and private hospitals. The *Intergovernmental Agreement on National Digital Health 2023-2027* and the NHRA incentivise state and territory governments to invest in digital health, but other providers are often not encouraged or have funding models that preclude such significant investments.[590]

To ensure effectiveness, solutions must be well-designed and address core challenges. Valuable insights from international and domestic experiences can guide successful implementation of these complex and costly initiatives.

The recent *NSW Special Commission into Healthcare Funding* highlighted the limited approach to implementing the Single Digital Patient Record and said the project should be immediately expanded to include Affiliated Health Organisations.[591]

EXAMPLE:

Governments have made significant investments in digital health, including:

- **New South Wales:** $1 billion over 10 years for a new Single Digital Health Record, to be delivered by Epic, replacing the existing Cerner system.[592]
- **Northern Territory:** A $259 million digital health system, Acacia, delivered by Intersystems' TrakCare, which was suspended shortly after its rollout in at Darwin's emergency department due to design shortcomings.[593]
- **Australian Capital Territory:** $151 million to implement a digital health record, to be delivered by Epic.[594]
- **Queensland:** The Integrated Electronic Medical Record (iEMR) received an initial $412 million in 2011, was estimated to cost $1.2 billion in 2016, and was paused in 2020 due to cost blow outs. A further $300 million was provided in 2022.[595]
- **Australian Government:** Approximately $2 billion for My Health Record. The Australian Government has also provided funding to private providers, including $220 million in grants for general practice and $20 million for aged care providers to upgrade their IT systems to meet their obligations under the *Aged Care Act 2024* (Cth).[596]

We suggest the Australian Government explore a range of assistance models, including private sector-led partnerships. For example, the introduction of a Digital Health and Care Interoperability Incentive Fund could support the digitisation of paper-based records and interoperability.

If this fund supported private hospitals at a cost of $1.3 billion over five years, it could lead to savings of more than $200 million per year by reducing duplicated pathology and diagnostic imaging alone.[597] The government needs to play a crucial role in advancing digital technology by providing clear planning, financial support and incentives.

Action 68

The Australian Government should continue to invest in and review regulatory barriers to use My Health Record and its supporting architecture so that it is easier to access and share information.

Action 69

The Australian Government should consider how My Health Record, the Aged Care Portal, the NDIS myplace portal and the Carer Gateway can become interoperable, subject to confidentiality and privacy considerations.

Action 70

The Australian Government should explore a range of assistance models, including private sector-led partnerships. For example, the introduction of a Digital Health and Care Interoperability Incentive Fund could support the digitisation of paper-based records and interoperability across the health and care system.

7.3.4 Innovation – medical technology and pharmaceuticals

Australia lags in terms of approvals and funding for new medical devices and medicines, and market access remains a problem. This deters companies from taking clinical trial research to manufacturing in Australia, which in turn limits our opportunity to develop advanced manufacturing. Cochlear is a prime example of a successful Australian company in this sector. Reforming these processes will create greater opportunities.

Therapeutic products are essential to safeguarding public health and maintaining workforce productivity. Many of these products are developed by companies that operate across the globe to leverage economies of scale. While Australia has a rigorous regulatory oversight framework through the Therapeutic Goods Administration (TGA), companies have reported that products submitted for TGA approval often experience avoidable delays, despite already being available in jurisdictions with high regulatory standards. We recognise some members have had positive experiences with the TGA and we encourage this ongoing work to ensure all companies receive clear and supportive advice.

However, these delays are frequently attributed to requirements for additional data not typically requested by equivalent overseas regulators. This imposes unnecessary burdens on sponsors, slows access to effective and reputable products, and increases costs ultimately borne by the government or consumers. There is an opportunity to review and consider where the regulation can be better aligned and reduce unnecessary duplication.

We recognise that not all standards need international harmonisation; Australia's unique environmental and cultural factors sometimes necessitate specific standards in some instances, such as our world-leading plain packaging tobacco requirements.[598] Though, Australia can better leverage international assessments by trusted regulators, allowing for more streamlined approval pathways that uphold safety and quality while reducing duplication.

Governments should ensure that our standards and regulatory framework align with international counterparts so Australians can access the latest technology and medicines. Avoiding bespoke frameworks can significantly boost productivity by reducing administrative and compliance costs, including saving time in product or service lifecycle management to meet regulatory requirements.[599]

EXAMPLE:

- **International:** Significant reforms, such as the ACCESS Consortium (Canada, Singapore, Switzerland, and the United Kingdom), and the Bridging Assessments and Concurrent Submissions options, have aimed to improve international regulatory alignment.[600]

Regulation and funding also need to be suitable for today and the future, including for the TGA, the Pharmaceutical Benefits Advisory Committee (PBAC), Medical Services Advisory Committee (MSAC) and Medical Devices and Human Tissue Advisory Committee (MDHTAC).[601] The Australian Government should aim for greater consistency by streamlining and reducing duplicative processes for medical technology and medicine listing, while maintaining clinical and consumer safety.

Governments should consider a 'tell us once' approach to avoid companies having to provide the same information, potentially in different formats, multiple times. A previous PC report has also outlined the fragmented and duplicated processes across all governments.[602]

Funding certainty is also required, and incentives must be recalibrated. Medical technology can be expensive, but it can also provide the ability to make savings elsewhere by allowing consumers to be monitored at home rather than in a clinical setting such as a hospital.[603] However, such technology that supports preventative or monitoring capabilities should not receive less funding simply because it is not in a clinical setting.

Australia should also continue to strive to be a global hub for medical device and medicine investment. This sector will be an important component of our system, and the technology will support improved health outcomes and ensure a better quality of life. We recognise the Australian Government's *Medical Science Co-investment Plan*, which outlines opportunities for government and industry to leverage Australia's strengths and target areas with high economic potential, including digital health, medical devices, innovative therapeutics and sustainability.[604]

However, governments should clearly outline a vision for the future use of medical technology and medicines, with supporting policies to enable Australian companies to remain onshore. As part of this, governments need to ensure the various funding incentives to support medical technology and medicines are aligned, providing Australians access to new technology and medicines. For example, recent protheses reforms resulted in prices for some medical devices being lower in the private setting than the public setting.

The Australian Government may wish to update the current *Biotechnology in Australia Strategic plan for health and medicine*.[605] It is a 'living document' which outlines the long-term plan for biotechnology in health and medicine.[606]

EXAMPLE:

- **Collaboration:** In 2022, the Queensland Government, Sanofi, the University of Queensland and Griffith University entered a $280 million partnership to establish the Global Translational Science Hub. This will drive vaccine development, create jobs and strengthen our biomanufacturing supply chain.[607]

Action 71

Governments should ensure our standards and regulatory framework align with international counterparts so Australians can access the latest medicines and technology. This includes reviewing and considering where regulation can be better aligned and reduce unnecessary duplication.

Action 72

The Australian Government should aim for greater consistency by streamlining and reducing duplicative processes for medical technology and medicine listing, while maintaining clinical and consumer safety. Governments should consider an 'tell us once' approach.

Action 73

Governments should clearly outline a vision for the future use of medical technology and medicines in Australia, with supporting policies to enable Australian companies to remain onshore. Funding incentives for medical technology and medicines should be aligned to provide Australians with access to new technology and medicines.

7.3.4.1 Pharmaceuticals

In 2021-22, the median time to achieve PBS listing after TGA registration was 21 months.[608] Currently, Australians wait an average of 466 days for a proven innovative medicine to be listed on the PBS, which is far longer than in most developed countries and has a direct impact on the health

of Australians.[609] One reason for our low mortality rates from preventative and treatable illnesses is access to medicines.[610] However, as new and more complex medicines emerge, this is becoming a challenge.

Delaying the listing of medicines on the PBS also undermines confidence in investing in research and clinical trials in Australia. This is and should be a major strength for Australia due the quality of our researchers and access to consumers. But if there are listing delays, companies will look elsewhere to conduct research.

The Standing Committee on Health and Aged Care and Sport has previously investigated approval processes for new drugs and novel medical technologies in Australia.[611] We recognise the Australian Government is working on implementing the *Health Technology Assessment Policy and Methods Review Final Report*.[612] This should be an urgent priority to ensure Australians can access medical technology and medicines in a timely manner.

The government must ensure that medicines remain affordable for Australians and that there is continued access to vital treatments. The PBS is a trade target from international counterparts.[613] Given the global climate, priority consideration should be given to the discount rate and comparator criteria.[614] Current processes fail to fully recognise and evaluate new initiatives, such as personalised medicine from genomic testing.[615]

Without reform, Australians risk losing access to the latest innovative medicines, as companies may deprioritise Australia due to burdensome and costly approval processes for the market and PBS access. This could lead to treatments being available only through private channels, increasing costs for consumers.

Action 74

The Australian Government should implement the recommendations of the *Health Technology Assessment Policy and Methods Review Final Report* as an urgent priority to ensure Australians can access medical technology and medicines in a timely manner. Priority consideration should be given to the discount rate and comparator criteria.

7.3.5 Research and development

In 2021, governments in 35 OECD countries for which data are available, collectively budgeted US $69 billion for health-related R&D.[616]

Australia's efforts to be a world leader in health and medical research is hampered by a lack of connection between research, translation and commercialisation, as well as a complex system and limited business support.[617] Our latest discoveries would not be possible without R&D. We have notable success stories, such as Cochlear, but delays in turning findings into practice continue to be a challenge.

In Australia, business expenditure on R&D was more than $24 billion in 2023-24 which is about 0.9 per cent of GDP.[618] More specifically, the proportion of health spending on research was 2.9 per cent in 2022-23.[619] We must increase our R&D spending, which is low by global standards. For comparison, the US government spent US $45 billion on health-related R&D and the global pharmaceutical industry spent US $129 billion on R&D in 2021.[620] To enhance the research commercialisation ecosystem and support economic growth, the Australian Government should commit to increasing R&D spend, with an aspirational goal of 3 per cent of GDP.

Global R&D investment is highly mobile, with intense competition between nations to attract it.[621] Many factors influence companies' decisions on locating R&D investment, but the competitiveness of a country's tax system is critical to attracting and keeping the commercial benefits of innovation.[622] Governments should action the recommendations in the BCA's *Unlocking Australia's R&D potential* report to ensure Australia is globally recognised to invest in and undertake research.[623]

We recognise the Australian Government's intention to develop a National Health and Medical Research Strategy to target funding and strengthen Australia's research capability.[624] This follows consultations to align the work of the National Health and Medical Research Council (NHMRC) and the MRFF.[625] This strategy should also consider other initiatives, including the National Reconstruction Fund (NRF), Future Made in Australia and the Australian Research Council.[626]

We suggest the Australian Government expedite the development of this strategy to provide certainty to researchers and industry. The strategy should address the commercialisation of research and the scaling of new models of care. The National Health and Medical Research Strategy Interdepartmental Committee must consult directly with researchers, including those in the private sector as they play an important role in this ecosystem.[627] Grant process reform is needed to reduce the administrative burden, which currently consumes excessive time and hinders vital research, despite good intentions.

Australia risks falling behind global innovation without stronger incentives and better coordination between industry, universities, and government. Competing nations move faster, invest more in innovation, adopt technology faster, and scale industries more effectively, making Australia less competitive.[628]

Successful international innovation policies are underpinned by well-established frameworks. In contrast, ongoing discussions about further changes to the Australian system, following the publication of the R&D Tax Incentive Transparency Data, are creating confusion.[629] The Australian Government needs to better explain and build confidence in the R&D Tax Incentive policy to ensure Australia remains a leading destination for R&D.

The frequent changes to tax incentives for R&D have also created uncertainty and impacted business confidence.[630] The arbitrary $150 million expenditure threshold further undermines the scheme.[631] The number of companies claiming the incentive has peaked and then stagnated.[632] Limiting support for larger businesses could be counterproductive, as they have a large propensity to innovate. The Australian Government should abolish the research and development expenditure threshold or, at a minimum, raise it to $250 million with indexation to attract greater investment.

EXAMPLE:

- **Competitiveness:** Cochlear is an Australian company leading in healthcare equipment R&D. Since 1998-99, Cochlear has invested around $1.7 billion on R&D, with the bulk of this in Australia. Without increasing the threshold, the relative attractiveness of Australia as a place to perform R&D will continue to fall. With global R&D capability, other countries frequently offer Cochlear incentives to increase their investment.[633]

We know that commercialising research is difficult. It can take up to 17 years to turn research into practice.[634] We cannot afford to let brilliant ideas wither simply because they cannot make the leap from research to real-world application. We suggest the Australian Government introduce a collaboration premium of up to 20 per cent on non-refundable tax offsets to incentivise partnerships between industry and public research organisations and universities.

Commercialising research, including medical technology and pharmaceutical innovations, remains a challenge. Existing initiatives such as the NHMRC, MRFF, Biomedical Translation Fund (BTF) and NRF can help by enabling greater collaboration with universities, researchers and providers. It is critical that Australia continues to innovate and support product development.

Action 75

The Australian Government should commit to increasing research and development spend, with an aspirational goal of 3 per cent of GDP.

Action 76

Governments should action the recommendations in the BCA's *Unlocking Australia's R&D potential* report to ensure Australia is globally recognised to invest in and undertake research.

Action 77

The Australian Government should expedite the development of a National Health and Medical Research Strategy to provide certainty to researchers. This strategy should address the commercialisation of research and scaling new models of care.

Action 78

Governments should provide stronger incentives and better coordination for research and development between industry, universities and government.

Action 79

The Australian Government needs to better explain and build confidence in the Research and Development Tax Incentive policy to ensure Australia remains a leading destination for research and development.

Action 80

The Australian Government should abolish the research and development expenditure threshold or, at a minimum, raise it to $250 million with indexation to attract greater investment.

Action 81

The Australian Government should introduce a collaboration premium of up to 20 per cent on non-refundable tax offsets to incentivise partnerships between industry, public research organisations and universities.

7.3.6 Artificial intelligence

Up to 30 per cent of the tasks undertaken by the workforce could be automated using digital technology and artificial intelligence (AI); precious time that could be spent caring for patients.[635]

AI has the potential to transform how we deliver care, improve productivity and allow our workforce to spend more time with consumers rather than on administration.[636] The application of AI in the health and care economy can carry high-risk, particularly around safety, algorithmic bias and privacy, but with careful oversight and responsible implementation, its benefits can be safely realised.[637]

AI can deliver significant benefits through improved diagnoses and easier, cheaper access to care.[638] Around the world, we are seeing increased use of AI in image-based risk screening, x-ray analysis and detection, administration and clinical decision support.[639] The OECD predicts AI could assist in developing vaccines against cancer, cardiovascular and autoimmune diseases by the end of the decade.[640]

The BCA supports regulation that addresses genuine high risks while ensuring Australia's regulatory approach to AI balances innovation and protection. The role our existing regulations play, and their potential shortcomings must be made clear. Governments should action the recommendations from the BCA's *Accelerating Australia's AI Agenda* report to ensure Australia becomes a globally recognised AI leader by 2028.[641]

EXAMPLE:

- **South Australia:** The recent decision by South Australia Health to ban AI scribes in the public setting highlights the challenge of balancing new innovations that reduce administrative burdens and improve efficiencies while managing potential clinical governance and consumer safety risks.[642]
- **Nationally:** The TGA has released updated advice on digital scribes, clarifying how this technology is regulated under the *Therapeutic Goods Act 1989* (Cth) and other legislation.[643]

We recognise the Australian Government's commitment to ensuring the uptake of AI is safe and responsible.[644] Consultations are underway on the use of AI in high-risk settings, with the Department of Health, Disability and Ageing and the TGA involved. We welcome the release of their respective findings and urge the Australian Government to action these as a priority to ensure we realise the full potential of AI.[645]

It is important that consumers have trust in AI but also that the government does not overregulate, undermining the potential significant positive outcomes it can provide. Consideration should be given to the Australian Alliance for AI in Healthcare roadmap which provides a strategic path forward.

The PC's *Delivering quality care more efficiently* interim report highlights that AI is valuable and suggests the Australian Government ensure a consistent approach to the regulation of AI across the aged care, NDIS and veterans' sectors.[646] AI can improve outcomes and productivity, with potential benefits including greater independence and quality of life, reduced costs and improved efficiency for providers and governments.[647]

Furthermore, the Australian Government needs to provide clear guidance on the role the TGA will play in regulating AI, as it is the regulatory body for clinical and medical devices. Our approach should not undermine providers' ability to safely and responsibly develop or deploy AI systems. Australia would do well to avoid the fate of Europe, where heavy-handed regulation has coincided with a marked slowdown in AI investment.[648] To harness the full productivity potential of these technologies, frontline health and care workers will require targeted training and digital upskilling.

We also need to build further trust in the use of AI and manage the associated cyber and privacy risks.[649] Given the potential risks, government and industry will need to work closely to set standards, clarify liability, and demonstrate the safe, transparent use of AI in real-world settings. Deployment sandboxes may offer a path forward, allowing providers to test new tools in controlled environments before broader deployment. Policymakers should also consider incentives to support adoption, particularly in under-resourced settings where upfront costs may be prohibitive.

Action 82

Governments should action the recommendations in the BCA's *Accelerating Australia's AI Agenda* report to ensure Australia is a globally recognised AI leader by 2028, supporting productivity.

Action 83

The Australian Government should consider as a priority the findings of the Therapeutic Goods Administration and the Department of Health, Disability and Ageing on the uptake and use of AI.

Action 84

The Australian Government needs to provide clear guidance on the role the Therapeutic Goods Administration will play in regulating AI as it is the regulatory body for clinical and medical devices. Our approach cannot undermine providers' ability to safely and responsibly develop or deploy AI systems.

Action 85

Collaboration between industry and government will be crucial and the use of sandbox models should be considered to enable the trial and use of AI technologies before scaling up. This will provide a safe environment.

7.4 A skilled workforce

Recommendation 4.

Strengthen the health and care workforce through adequate workforce planning and training to ensure it is productive and skilled.

Expanding our workforce by using new models of care and flexibility to adopt new innovations will be critical to meeting the demands of an ageing population and the increasing burden of disease.

Australia is facing significant workforce shortages, with an estimated shortage of 79,000 nurses by 2035 and close to 9,000 GPs by 2048.[650]

The health and care economy is labour-intensive, with wages making up the largest expense.[651] Boosting productivity and retention in the sector requires enhancing worker capabilities, offering career development opportunities, and implementing innovative workforce models to make employment more attractive.[652] Earlier in this report, we discussed the role of technology in alleviating these shortages.

Labour shortages are an ongoing issue, with job dissatisfaction, burnout and fatigue impacting workers.[653] Australia's health and care workers are also getting older, which means there is an urgent need to attract and train a new generation.[654] It is crucial to boost productivity in parallel with attracting and retaining skilled professionals. Policy settings must enable workers to be productive and perform to their full potential.

7.4.1 Workforce productivity

The BCA recognises the critical contributions made by health and care workers, including nurses and those in aged care. We support productive, inclusive, flexible and diverse workplaces that create well-paid and rewarding jobs. We have previously welcomed extra funding for wage increases for aged care workers.[655]

However, as mentioned, PC Chair Danielle Wood has highlighted the ongoing difficulty of improving productivity in labour-intensive industries.[656] For these essential services to be sustainable, wage increases must be supported by efficient workforce planning and continued system reform. Tangible productivity gains must also be an integral part of workforce changes to ensure the system remains sustainable.

There is significant opportunity to use new and different ways of working to support innovative models of care, such as remote monitoring and telehealth.[657] Greater flexibility in how health and care workers provide services across the broader economy – including primary, secondary, tertiary and aged care – will also alleviate workforce pressures and improve outcomes.[658]

More flexible employment arrangements should be considered, allowing health and care workers to gain experience and provide services in various care settings. This is especially important as we move towards multidisciplinary teams, co-commissioning and new models of care. Greater flexibility could also help attract more workers to regional, rural and remote areas.[659] A more flexible labour market can enable workers to access higher-paying jobs and providers to find the best-matched worker.[660]

To meet the changing needs of the system, employers (private and public sectors) should be able to utilise engagement models that support innovation, productivity, operational needs and workers' preferences, including a mix of permanent, fixed-term, casual, on-hired, contracting, and on-demand workers. Individual providers may have their own operational requirements, with some preferencing full-time and part-time staff to ensure the continuity of care and delivery of quality services.

A siloed focus on employment models, despite the preferences of workers and providers for increased flexibility, can come at the expense of optimum job matching for workers and employers,

and consequently productivity. This also does not consider that the casual employment rate has remained between 22 per cent to 23 per cent since August 2020 and has not fluctuated much since the mid-1990s.[661]

Governments, providers and unions must also recognise that health and care roles will change, and new jobs will emerge. While consumer safety is paramount, and a skilled workforce is necessary, rigid workplace models can discourage and complicate the uptake of new delivery models. This includes demarcations between clinical care workers including scope of practice reforms and the facilitation of AI.

EXAMPLE:

- **Paperwork:** The introduction of care minutes in residential aged care provides a good illustration of rigid regulatory conditions. While well intentioned, the extra paperwork can take time away from providing quality care and may not reflect the specific needs of each facility and its residents. Different approaches to the staffing mix can also help deliver the same or better outcomes.

In addition, a lack of parity in wages across health, disability and aged care creates competition for workers.[662] This can make it difficult to attract workers in particular services or areas. Increases in wages come at a cost, and one which government must consider – who is to pay for both the public and private sector?

Public sector wage increases, funded by taxpayers, risks undermining the sustainability of private hospitals and private health insurers if no mechanism exists to adjust for these costs in the private sector. For instance, changes to the nurses' award in private hospitals will impact PHI premiums.

The Australian Government must acknowledge the cost pressures from wages increases, particularly the impact on the sustainability of private hospitals and private health insurers. Consideration should be given to specific government funding to support these wages increases without impacting PHI premiums.

Between 2021 and 2024, the Fair Work Commission (FWC) conducted a wide-ranging aged care work value case, leading to significant wage increases across the:[663]

- Aged Care Award 2010
- Nurses Award 2020, and
- Social, Community, Home Care and Disability Services Industry Award 2010.

These increases, ranging from 2.4 per cent to 13.5 per cent, built on the 15 per cent interim increase awarded to nurses and personal care workers, among others, in 2023.[664] The Australian Government has committed to supporting increases for publicly-funded aged care facilities with more than $15 billion for the Stage 2 and Stage 3 decisions.[665]

The FWC has also conducted a work value case for nurses and midwives in 2024, with a decision for private nurses still pending.[666] A further FWC proceeding is underway to review gender undervaluation across other priority awards, including:[667]

- Aboriginal and Torres Strait Islander Health Workers and Practitioners and Aboriginal Community Controlled Health Services Award 2020
- Children's Services Award 2010
- Health Professionals and Support Services Award 2020
- Pharmacy Industry Award 2020, and
- Social, Community, Home Care and Disability Services Industry Award 2010.

We recognise these awards have different funding structures; however, these decisions will likely have an impact on the sustainability and cost pressures of the system.

We also need to simplify and modernise awards to make them easier to navigate and apply across the health and care system. Awards based on current ways of working will not keep pace with changing models of care and service delivery settings, such as telehealth and care in the home.[668]

The *NSW Special Commission into Healthcare Funding* recommended the Industrial Relations Commission of NSW undertake an award reform process to simplify and consolidate awards, provide a consistent framework, and update instruments to reflect future service delivery needs.[669]

Action 86

All stakeholders, including governments, unions and providers need to increase flexibility and remove rigidity in workplace laws to support innovation, productivity, operational requirements and workers' preferences.

Action 87

All stakeholders need to limit rigid regulatory conditions and standards that do not necessarily increase the quality of care, as these can hinder productivity, limit workforce flexibility and mobility, and inhibit new models of care.

Action 88

The Australian Government must acknowledge the cost pressures from wages increases, particularly the impact on the sustainability of private hospitals and private health insurance.

Action 89

Awards should be simplified and modernised to make them easier to navigate and apply across the health and care system.

7.4.2 Workforce planning and reporting

Workforce pressures have been exacerbated by changes in worker preferences since COVID-19, including an increase in part-time roles.[670] While the number of workers continues to increase, the number of hours worked are declining.[671]

The PC's *Report on Government Services* highlights an ageing workforce, with 26.6 per cent of full-time equivalent GPs aged 60 years or over.[672] Furthermore, the Department of Health, Disability and Ageing's Nursing Supply and Demand report highlights an undersupply of over 70,000 full-time equivalent nurses across all sectors by 2035, with approximately 79,000 nurses needed to fill this gap (refer to figure 31).[673]

While Health Workforce Australia was previously abolished to reduce duplicated functions, reports continue to highlight the significant workforce shortages.[674] The *Mid-term Review of the NHRA* suggested a body be responsible for national workforce planning and oversight across health, aged care and disability.[675] Similarly, the *NSW Special Commission into Healthcare Funding* also recommended a system-wide approach to workforce planning.[676]

It is clear workforce remains an issue, despite the *Royal Commission into Aged Care Quality and Safety* recommending the establishment of an Aged Care Workforce Planning Division within the Department. Given these ongoing issues, and the substantial work already tasked to Jobs and Skills Australia, we suggest the Australian Government take a whole-of-system approach to workforce planning across the health and care economy. The Department of Health, Disability and Ageing should create an overarching Workforce Division and amalgamate existing siloed workforce areas.

This division would be responsible for national workforce planning, delivery and oversight across health, aged care and disability. Consideration should be given to the development of a national public dashboard or database to understand workforce demand and supply. The division should also oversee the implementation of existing strategies which currently silo workforce planning across different sectors, for example the;[677]

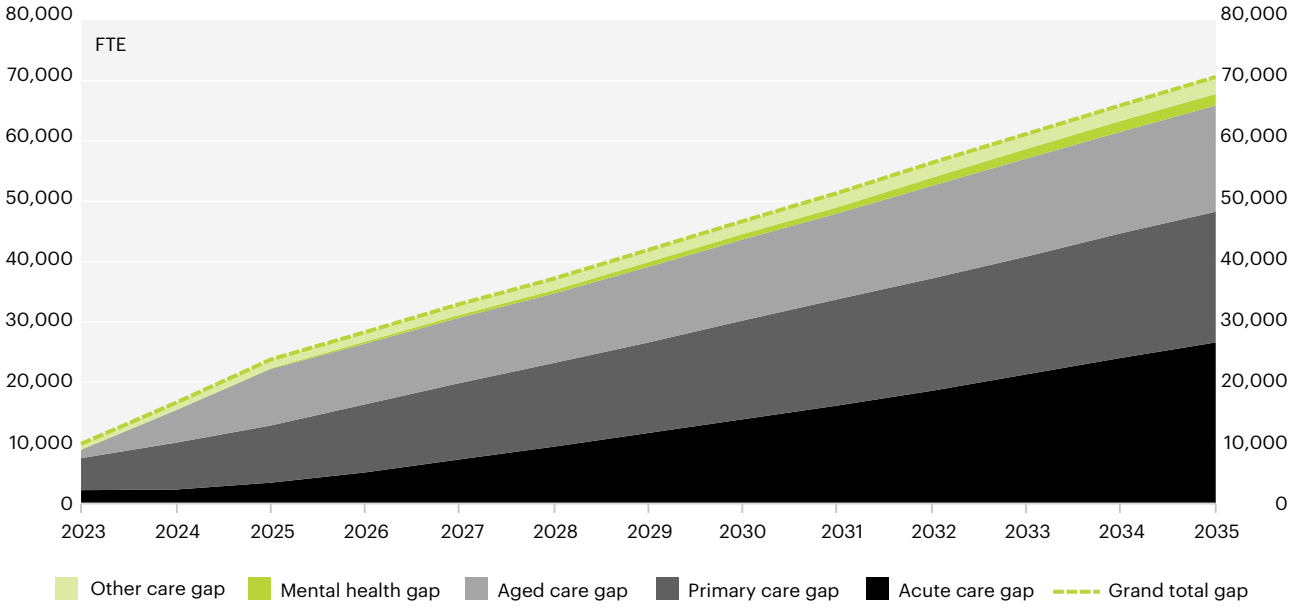
- Medical Workforce Strategy
- Nurse Practitioner Work Plan
- National Nursing Strategy (in progress)
- National Allied Health Strategy (in progress).

This aligns with our other recommendations for a more holistic view of the health and care economy, including both the needs of the public and private systems.

Currently, there remains a lack of robust and accessible data for all stakeholders to determine workforce demand and supply.[678] An evidence-based review by the Health Research Board in Ireland on health workforce planning found similar challenges with data quality and collection across five countries, including Australia.[679]

To support the implementation of these strategies, all stakeholders – governments, unions, providers – should seek to strengthen workforce data and reporting requirements. This would enable a national approach to easily identify demand, supply and potential gaps. Data projections could also include new health and care builds in each jurisdiction, and consideration of changing models of care and funding models.

Figure 31: Nursing full-time equivalent – National supply and demand



Source: Commonwealth of Australia, Department of Health and Aged Care. (2024). *Nursing Supply and Demand Study 2023-2025*

The proposed Australian Health and Care Planning and Delivery Agency or the proposed Australian Health and Care Commission should develop and release biannual reports on future workforce needs. This would enable all stakeholders to understand expected demand and supply across geographical locations and to identify likely gaps. This should be developed in consultation with the proposed Australian Health and Care Economy Practitioner Regulation Agency and education providers.

Action 90

The Australian Government should take a whole-of-system approach to workforce planning and delivery across the health, disability and ageing. The Department of Health, Disability and Ageing should create an overarching Workforce Division and amalgamate existing siloed workforce areas.

Action 91

All stakeholders should seek to strengthen workforce data and reporting requirements to enable a national approach that can easily identify demand, supply and potential gaps.

Action 92

The proposed Australian Health and Care Planning and Delivery Agency or the proposed Australian Health and Care Commission should release biannual reports on future workforce needs. This should be done in consultation with the proposed Australian Health and Care Practitioner Regulation Agency and education providers.

7.4.3 Australian Health and Care Practitioner Regulation Agency

As Australia's health and care economy grows, it needs to become more flexible while ensuring the workforce remains adequately educated, trained and skilled. Established in 2010, the Australian Health Practitioner Regulation Agency (AHPRA) works in partnership with 15 independent National Boards to ensure health practitioners are suitably trained and qualified.[680]

We recognise the ongoing *Independent review of complexity in the National Registration and Accreditation Scheme*.[681] We suggest National Cabinet, in consultation with clinical bodies and providers, rename AHPRA to the Australian Health

and Care Practitioner Regulation Agency and expand its remit to oversee the broader health and care workforce, including health, aged care and disability.

This is supported by the *Mid-term Review of the NHRA,* which recommended the continued development of the national regulation scheme.[682] An expanded agency could also incorporate the national registration scheme for personal care workers recommended by the *Royal Commission into Aged Care Quality and Safety*.[683]

The *Aged Care Act 2024* (Cth) demonstrates that broader recognition of workers across the health and care workforce is possible by strengthening NDIS worker screening processes for aged care.[684] The PC interim report into *Delivering quality care more efficiently* also suggests aligning worker regulation by developing a national screening clearance as well as a unified approach to worker registration.[685]

Any solution must be risk-based to remain a sustainable model while providing consumers with adequate protection and certainty that the workforce is appropriately regulated. We are willing to engage in this process as solutions are considered.

Action 93

National Cabinet, in consultation with clinical bodies and providers, should rename the Australian Health Practitioner Regulation Agency to the Australian Health and Care Practitioner Regulation Agency with an expanded remit to oversee the broader health and care workforce.

7.4.4 Job design and scope of practice

While "scope of practice" is not necessarily legislative, it generally refers to the activities a worker can perform based on their education, training and competency.[686] Governments continue to address and amend legislative barriers that prevent health and care workers from performing their jobs.[687] Scope of practice reforms should focus on consumer benefits while maintaining quality, safe care.

Over recent decades, we have seen workers move from operating in siloes to working in multidisciplinary teams. We can do more to allow workers to perform to their full scope of practice. This also means utilising technology to support them in their jobs.

Many workers are qualified to deliver care, but a range of issues with job design, planning, legislation, regulation and funding limit their ability to deliver their broader capabilities.[688] A previous PC report recommended state and territory ministers to initiate role expansions, based on evaluations of past and current trials, and amend scopes of practice accordingly.[689]

All stakeholders, including governments, clinical bodies, unions and providers should review existing job designs and ensure these are still fit-for-purpose and relevant given the changing nature of the system, including the use of technology and new models of care. Our federated system and split public and private service delivery add further complexities.

EXAMPLE:

- **Insurance:** The *Health Insurance Act 1973* (Cth) and its legislative instruments do not provide MBS-funded pathways for Registered Nurses to conduct patient attendances for purposes, such as assessing mental health needs and instigating a mental healthcare plan.[690]

To further support job design, the BCA supports the findings of the *Unleashing the Potential of our Health Workforce Scope of Practice Review – Final Report* and urges governments to implement these recommendations.[691] We also urge governments to apply these findings to other settings, including aged and tertiary care, with appropriate clinical governance. Australia does not and will not have the workforce to deal with an ageing population and increasing chronic disease burden, making this reform essential if we are to lift productivity within our current workforce and meet future demand.

As an example, we have yet to fully realise the potential of nurse practitioners in Australia, with only about 2,000 in practice.[692] Nurse practitioners who hold a master's degree, can access some MBS rebates, refer consumers to other services, prescribe PBS medicines, and order radiology and diagnostic tests.[693]

We support the findings of the *MBS Review Advisory Committee Surgical Assistants Final Report November 2022,* including that suitably qualified nurse practitioners should provide funded assistance in surgery. [694] The Australian Government should action these findings and introduce MBS items to provide greater access to services, reduce workforce shortages and better use skilled workers. A previous PC report recommended the Australian Government identify where there would be benefits in expanding the types of health professionals that can access reimbursement for MBS and PBS items, while monitoring the effectiveness of any changes.[695]

We recommend that the Australian Government undertake a review to determine whether nurse practitioners and other workers, such as paramedics, can play a much more active role across a broader range of services to help address workforce challenges. Evidence shows nurse practitioners can play a greater role supporting medical and nursing teams.[696] We recognise new funding has been approved for nurse practitioners to deliver care, but there is more to be done.[697]

EXAMPLE:

- **Workforce:** Ramsay Health Care has invested in growing its nurse practitioner workforce. However, with limited funding options, they are unable to fully leverage these skilled professionals in its private hospitals. Expanding access to this workforce would not only improve treatment availability but also offer a more cost effective approach to care.

Health and care workers should be able to perform the tasks for which they were trained. Scopes of practice should align with a profession's competency, education and skills. A risk-based approach should inform any changes to scope of practice to ensure the delivery of safe care. This will help improve productivity by embedding these practices across the health and care system. This will require strong collaboration across jurisdictions, including with education and service providers.

Action 94

Governments, clinical bodies, unions and providers should review existing job designs and ensure these are still fit-for-purpose and relevant given the changing nature of the system, including the use of technology and new models of care.

Action 95

Governments should implement the findings of the *Unleashing the Potential of our Health Workforce Scope of Practice Review – Final Report* to enable health and care workers to work to their full scope of practice and provide multidisciplinary care.

Action 96

All governments should consider the findings of the *Unleashing the Potential of our Health Workforce Scope of Practice Review – Final Report* and apply these findings to other settings, including aged and tertiary care, with appropriate clinical governance and standards.

Action 97

The Australian Government should action the findings of the *MBS Review Advisory Committee Surgical Assistants Final Report November 2022* and introduce Medicare Benefits Schedule (MBS) items for nurse practitioner surgical assistants in private practice to provide greater access to services, reduce workforce shortages and better use skilled workers.

Action 98

The Australian Government should undertake a review to determine whether nurse practitioners and other health and care workers such as paramedics can play a more active role across a broader range of services to help address workforce challenges.

7.4.5 Education and Training

Education and training are essential for maintaining a skilled and trained workforce. This includes undergraduate and postgraduate studies, as well as the attainment of microcredentials. Our proposed Workforce Division within the Department of Health, Disability and Ageing would be central to a holistic approach to ensure Australia has the skilled workforce needed for the future.

Governments, clinical bodies, education providers (universities, TAFE, VET) and health and care providers should ensure that education and training courses incorporate new models of care and leading burdens of disease, such as dementia, digital technology, AI and genomics. All stakeholders must ensure their courses prepare students to be workforce ready.

Governments and education providers should also work towards greater harmonisation and mobility of qualifications. This would allow students to change their study interests while receiving credit for any prior study. For instance, a student with a Diploma of Nursing receives 12 months of credit for a Bachelor of Nursing, but a student with 12–24 months of a Bachelor of Nursing receives no credit, if they transfer to a Diploma of Nursing. Consideration could also be given to developing a standard VET course for the health and care economy that covers core basic principles, allowing students to then choose a specialist stream like nursing or allied health.

EXAMPLE:

- **Barriers:** A Master of Audiology often provides very little education on the role of cochlear implants, with much of the teaching focusing on hearing aids and devices. This hinders the diffusion of the latest knowledge and the opportunity for workers to leverage the latest technology and models of care, which in turn limits Australian's access to these services.

The *Mid-term Review of the NHRA* also called for greater transparency in funding and investment for teaching and training functions.[698] With readily available and usable data, the Australian Government and education providers should review and adjust the number of commonwealth-funded and VET placements for health and care workers where gaps have been identified, including medicine, nursing and allied health. Consideration must also be given to postgraduate studies to support upskilling. This must be done regularly to ensure Australia builds a sustainable domestic workforce, especially for regional, rural and remote areas.

We welcome the Australian Government's recent announcement to strengthen the domestic workforce, with additional Commonwealth supported places from 2026.[699] We understand the focus is on growing our GP workforce, however, further support will likely be required for other specialties, such as psychiatrists.

Health and care workers also typically undertake on-site training, and this should remain a prerequisite. We welcome the Australian Government's introduction of a Commonwealth Prac Payment to help students manage costs associated with mandatory placement.[700] This is a significant investment of $427.4 million over four years from 2024-25, covering teaching, nursing and midwifery, and social work in both tertiary vocational education and training.[701]

The Australian Government should consider expanding the Commonwealth Prac Payment to other health and care roles where gaps may exist, such as occupational therapists and speech pathologists. It will be important to maintain means-testing and review the payment periodically to ensure the right people are receiving support.

To further support scope of practice and upskilling, we need to incentivise government, business and the tertiary sector, in partnership with clinical bodies, to develop microcredentials. This could also include targeted government funding to enable workers to upskill, which may include targeted postgraduate scholarships. Consideration may also be given to credentialling technology requirements and standards. This should be done in consultation with clinical bodies.

There are ample opportunities for the public and private systems to attract workers to the regions through shared recruitment, provision of support staff, or guaranteed hours across both systems. For instance, a GP may wish to work in a local practice or aged care facility, while a specialist may wish to work across both private and public hospitals.

EXAMPLE:

- **Training:** Ramsay Health Care and Bupa Australia have partnered to launch a program to develop the next generation of nurses. Graduate hospital nurses will do a rotation in aged care, while graduate aged care nurses will rotate through a private hospital.[702]

Governments should further encourage public and private partnerships that educate and train the health and care workforce by enabling them to work across different settings, particularly in regional areas. This includes appropriate funding for both public and private providers, recognising the private sector's capacity and expertise to offer additional training opportunities.

Governments may also wish to consider other private sector workforce incentives to support workforce training, such as tax offsets for hosting clinical placements and for enrolling staff in university programs to upskill. Few government funding programs currently support private sector training, despite private hospitals performing 67 per cent of elective surgeries.[703]

Private hospitals play a significant role in training junior doctors and registrars through limited government funded programs such as the Junior Doctor Training Program and the Specialist Training Program.[704] This is critically important to continue given the proportion of activity that takes place in private hospitals.

Action 99

Government, clinical bodies, education providers and health and care providers should ensure education and training courses incorporate new models of care and leading burdens of disease, such as dementia, digital technology, AI and genomics. All stakeholders must ensure their courses prepare students to be workforce ready.

Action 100

Governments and education providers should work towards greater harmonisation and mobility of qualifications to allow students to alter their study interests while receiving credit for any completed study.

Action 101

The Australian Government and education providers should review and adjust the number of commonwealth-funded and VET placements for health and care workers where gaps have been identified, including medicine, nursing and allied health. Postgraduate studies should also be considered to support upskilling.

Action 102

The Australian Government should consider expanding the Commonwealth Prac Payment to roles where gaps appear, such as occupational therapists and speech pathologists. It will be important to maintain means testing and review periodically to ensure the right people are receiving support.

Action 103

Government, business and the tertiary sector should be incentivised, through targeted funding to develop microcredentials to lift skills, enhance career progression, and better use the workforce. This should be undertaken in consultation with clinical bodies.

Action 104

Governments should encourage public and private partnerships that educate and train the health and care workforce by enabling them to work across settings, particularly in regional areas. This includes ensuring appropriate funding for private providers, given their capacity and expertise to offer training opportunities.

Action 105

Governments may also wish to consider other private sector workforce incentives to support workforce training, such as tax offsets for hosting clinical placements and for enrolling staff in university programs to upskill.

7.4.6 Overseas trained workforce

An extra 13,000 medical practitioners, 40,000 nurses and 27,000 allied health professionals are likely to be needed by November 2026.[705]

While Australia has some of the highest rates of overseas-trained doctors and nurses globally, there is intense competition to attract and retain these workers (refer to figure 32). In 2023-24, over 16,600 internationally qualified nurses registered to practice in Australia.[706] Over the long-term, Australia should aim to reduce its reliance on an overseas workforce and instead build a strong domestic pipeline. However, in the short term, the use of overseas-trained workers is necessary given the time it takes to train professionals. There are particular shortages that require immediate action, such as mental health and paediatrics.

The Independent Review of Australia's Regulatory Settings Relating to Overseas Health Practitioners provided important recommendations to make it simpler, faster and cheaper for international practitioners to work in Australia.[707] We recognise and support National Cabinet's ongoing implementation of these recommendations to streamline access to professionals with in-demand skills. The proposed Workforce Division within the Department of Health, Disability and Ageing should play a central role to support the ongoing implementation of these recommendations.

The BCA emphasises the importance of private-sector representation on the Health Workforce Taskforce which provides advice and recommendations to health ministers and oversees national strategies.[708] A national approach cannot be effective without the perspectives of all system components. Governments should consider how to work more closely with the private sector.

Evidence suggests the time an international medical graduate must wait for their application to be assessed and finalised has decreased from 110 days to 87 days.[709] This is a positive step forward. However, there needs to be a greater coordination between the Department of Health, Disability and Ageing, the Department of Home Affairs, APHRA and Services Australia to ensure applications are processed efficiently. The average time for a qualified foreign doctor's application to be assessed has also decreased, but there are still long waiting lists for Objective Structural Clinical Examinations (OSCE) for nurses and midwives, which are currently only offered in South Australia, and Victoria.[710]

It is important to have a balanced approach to overseas-trained health and care workers, especially in regional, rural and remote Australia. While there is a greater need for workers in these areas, there is often limited support from professional counterparts. Adequate clinical support is essential, as is cultural safety training.[711] The clinical colleges will play a role in supporting the development and implementation of these services.

We suggest governments and providers should consider providing supports and wrap-around services for internationally trained workers, including adequate clinical support and appropriate cultural safety training to deliver care to Aboriginal and Tores Strait Islander communities. This may include targeted education to help understand how care is funded and delivered in Australia.

The Australian Government should also consider enhancing education and training programs for international workers. This would have the dual benefit of filling urgent vacancies in Australia, and these workers could then return to their home countries trained to deliver care to their local populations. For example, the Pacific Australia Labour Mobility program enables Australian businesses to hire workers from nine Pacific nations.[712]

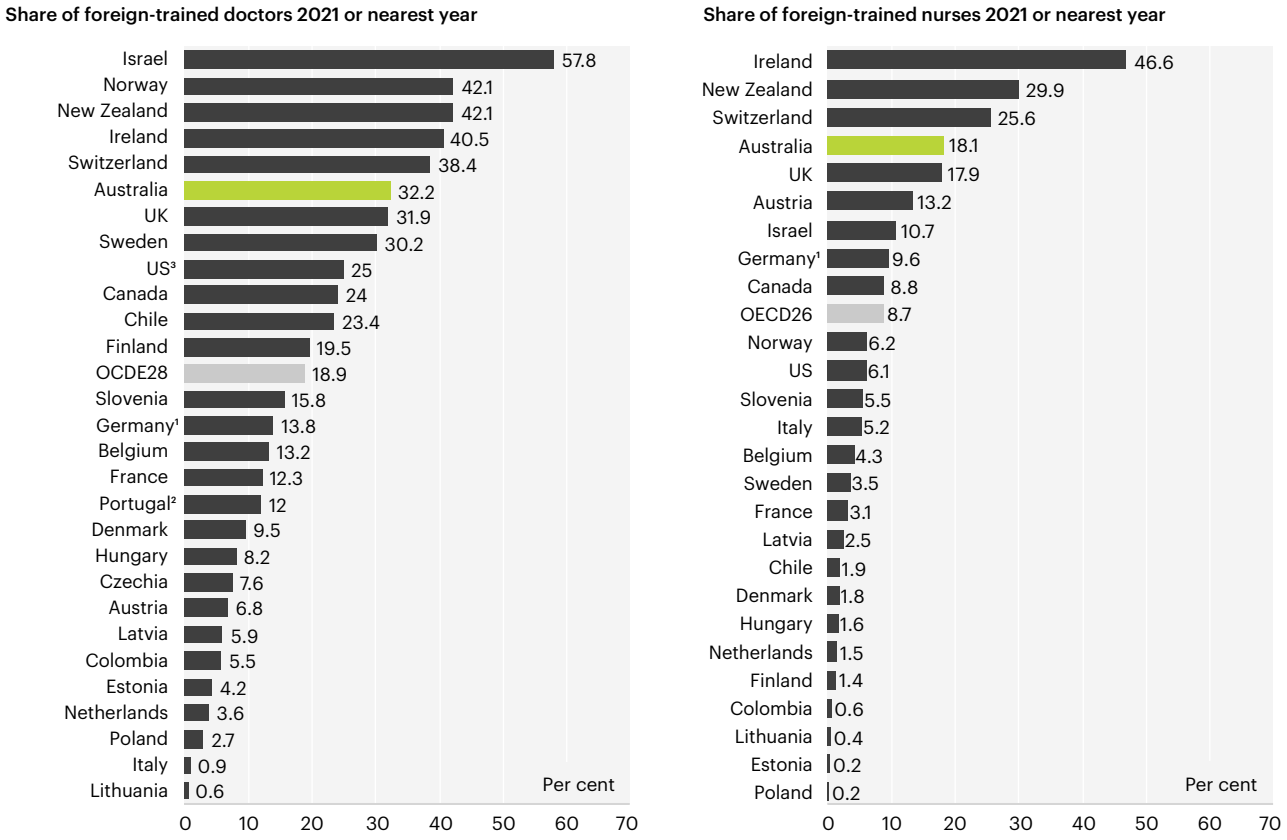
Action 106

Australia needs to reduce its reliance on overseas-trained health and care workers and build its domestic pipeline, with exceptions for short-term needs.

Action 107

National Cabinet should continue to implement the recommendations of the *Independent Review of Australia's Regulatory Settings Relating to Overseas Health Practitioners* to streamline access to professionals with in-demand skills.

Figure 32: Share of foreign-trained doctors, 2021 (or nearest year) and share of foreign-trained nurses, 2021 (or nearest year)



1. In Germany, data are based on nationality (not on place of training)
2. Data from 2017
3. Data from 2016 OECD Health Statistics 2021

Source: OECD.

Action 108

Greater coordination is needed between the Department of Health, Disability and Ageing, the Department of Home Affairs, the Australian Health Practitioner Regulation Authority and Services Australia to ensure applications are processed efficiently and to improve access to Objective Structural Clinical Examinations.

Action 109

Governments and providers should consider providing supports and wrap-around services for internationally trained workers, including adequate clinical support and appropriate cultural safety training. This may include targeted education to help understand how care is funded and delivered in Australia.

Action 110

The Australian Government should consider enhancing education and training programs for international workers that provides both employment opportunities in Australia while delivering care. These workers could return fully equipped to deliver care to their home country's population.

7.4.7 Decline in Carers

As the number of older Australians increases, fewer family and friends are able to provide informal care. The PC has identified the ageing population, changing family structures and more women in the workforce as contributing to the decline.[713] Recognition of unpaid carers is paramount, as they play a vital role in supplementing government-funded paid care and services.[714]

The BCA encourages the Australian Government to respond to the House of Representatives Standing Committee on Social Policy and Legal Affairs *Inquiry into the Recognition of Unpaid Carers* which sets out 22 recommendations.[715] We acknowledge the launch of the Australian Government's *National Carer Strategy 2024-2034*.[716]

The tax and transfer system must also consider the barriers to taking on carer roles. The BCA has previously proposed a non-refundable progressive Carers' Income Tax Offset for unpaid carers, paid upon their return to the workforce. This would be for carers supporting family members who are aged, have disabilities, or are chronically ill.

The recent improvement in flexibility around hours worked for carer payment recipients, by changing the 25 hour per week rule for recipients of the carer payment to instead allow up to 100 hours over a 4-week settlement period, as called for in the BCA's 2024-25 Budget Submission, is a welcome step forward.[717]

Action 111

The Australian Government respond to the House of Representatives Standing Committee on Social Policy and Legal Affairs *Inquiry into the Recognition of Unpaid Carers*.

Action 112

The Australian Government should consider a non-refundable progressive Carers' Income Tax Offset for unpaid carers, paid upon their return to the workforce. This would be for carers supporting family members who are aged, have disabilities, or are chronically ill.

7.5 Complementary public and private systems

Recommendation 5.

Enable greater access to services by supporting a complementary and dynamic public and private health and care system.

Building an evolving and sustainable health and care market that fosters collaboration and dynamism between our complementary public and private systems will allow Australians to access quality and safe care.

Australia is in a unique position to leverage the strengths of both its public and private systems to enhance service delivery, increase efficiency, support innovation and improve consumer outcomes and experiences. The two systems are complementary. Clear funding and accountability responsibilities across both public and private sectors will help deliver efficient, safe, quality care.[718]

By encouraging dynamism between the two systems, governments can help ensure that services are adaptable and meet the changing needs of the population, providing greater choice and improving quality.[719]

Australia must effectively utilise public-private partnerships (PPPs) to make more effective use of resources, including workforce and capital. PPPs will play a crucial role moving forward. Successful examples of existing PPPs include:

- Joondalup Health Campus, Perth with Ramsay Health Care
- The Royal Adelaide Hospital with Celsus
- Calvary Mater Newcastle Hospital with Calvary Health Care, and
- The Surgical Treatment and Rehabilitation Service Hospital, Brisbane with the University of Queensland under a 20-year lease with Australian Unity.

7.5.1 Role of the private sector

Australia's health and care system includes services provided by the private, not-for-profit and public sectors.[720] This model continues to deliver excellent outcomes for Australians, as demonstrated by highly favourable international comparisons and analysis of value for money.[721]

As challenges facing the health and care economy increase, cooperation between these sectors will become increasingly important. Each sector has a vital role to play and must be productive and highly efficient to meet consumer demand and expectations. To achieve this, each sector needs to be able to adapt, adopt new technologies, secure its workforce, and access sustainable funding.

Government alone cannot meet these challenges and must therefore work more collaboratively with the private sector. The PC acknowledges that the private sector is efficient in delivering many services.[722] However, in some areas, particularly with a diverse and dispersed population, it may not be viable for private providers to deliver all services.[723] Similarly, the reverse is also true. Careful consideration must be given to the best way to deliver care, based on outcomes rather than ideology. This may include collaborative commissioning with the public, not-for-profit and private sectors.

Despite the financial challenges facing some of Australia's private hospitals, the health sector as a whole could not handle demand if private services were to close.[724] We recognise the Australian Government's establishment of the Private Health Chief Executive Forum and the recent *Private Health Reform Options* consultation process to address some of the viability issues faced by private hospitals.[725] These initiatives include the private sector at the policy-making table.

However, there are instances where the private sector is not represented on government advisory bodies and partnerships, including the NHRA, the NSW Elective Surgery Taskforce and the Australian Government Mental Health Reform Advisory Group.[726] Given that private hospitals deliver approximately 67 per cent of elective surgeries and treat 41 per cent of hospitalisations, private sector representation on these bodies is critical for a holistic approach to service delivery.[727] This is

also important for sectors such as oral health and allied health, where the private sector provides the lion's share of services to the community.[728]

Governments should ensure private sector representation on government advisory bodies and partnerships for a holistic approach to service delivery. This should preference companies which deliver services. Representation may not apply to all advisory bodies or partnerships.

Furthermore, the private sector has the capacity to play a greater role in reducing the number of people waiting for elective surgery. However, the number of private patients in public hospitals is increasing, particularly in metropolitan areas. With increasing pressure on the public system, it is crucial that private patients are treated in a private setting where it is clinically appropriate to do so.

Similarly, in aged care, the main provider of services is the private sector, including both the not-for-profit and for-profit providers (refer to figure 3).[729] A fresh look at how these services are funded is required, with accountability being a key consideration.

If the consumer or taxpayer is paying for a service, they expect choice and accountability. This is something all parties – federal, state and territory governments, the not-for-profit sector and private operators – must take into consideration.

Greater private sector involvement in future health and care provision will be required if Australia is to confront its demographic challenges of a proportionately smaller workforce and a larger cohort of retirees, with higher life expectancies, and an increase in chronic conditions.[730] The *Intergenerational Report 2023* and the *Budget 2025-26* are all illustrative in this regard.[731]

Governments also need to recognise the role of the private sector and improve understanding of how to valuably increase engagement across sector participants. The public system will not be able to manage the projected future demand. Therefore, governments should not reduce their appetite to engage with the private sector in the delivery of quality health and care services.

Measures that limit the ability of the private sector to deliver services, such as legislative restrictions on public-private partnerships, need to be carefully considered. Equity will be an important element to consider in future partnerships to ensure all Australians can access the services they require.

It is important that any issues that arise in a partnership are investigated and addressed. This includes ensuring appropriate governance, contracting, procurement and regulatory arrangements are in place, before a partnership is established and throughout its lifetime.

Action 113

Governments should ensure private-sector representation on government advisory bodies and partnerships for a holistic approach to service delivery. This should preference companies which deliver services. Representation may not apply to all advisory bodies or partnerships.

Action 114

Governments need to recognise the role of the private sector and improve understanding of how to valuably increase engagement across sector participants.

7.5.2 Dynamism

Australia's ageing population will impose greater demands on health and aged care services. Establishing choice and contestability in government provision of human services can improve services for those who most need them. If managed well, this can both empower service users and improve productivity at the same time.[732]

Dynamism in the health and care economy is important to ensure it delivers ongoing improvements in productivity and outcomes for consumers. That is why greater accountability and coordination is required. Reform is needed across government service delivery to enable consumer choice, and drive value and innovation.[733] We also recognise equality of access to quality services and universal service provision are important considerations.[734]

We support the Treasury's *Revitalising National Competition Policy* consultation paper, which identified harnessing choice, competition and contestability in human services as a key reform theme.[735] We are concerned the current work of

the Taskforce has not adequately addressed this theme. We suggest the Australian Government recommit to addressing these principles to ensure effective service delivery across both the public and private sectors while meeting the needs of an ageing population.

The BCA considers that the following objectives for the *Revitalising National Competition Policy's* reform agenda should be adopted in the context of health and aged care:[736]

- Allow consumers to choose the most suitable service provider.
- Streamline regulations that have unintended impacts on labour mobility in human services.
- Reduce costs and improve access to necessary health services and products.

We also draws attention to the competition principles from the *Harper Review's* which remain highly relevant today:[737]

- User choice should be placed at the heart of service delivery.
- Governments should retain a stewardship function, separating the interests of policy (including funding), regulation and service delivery.
- Governments commissioning human services should do so carefully, with a clear focus on outcomes.
- A diversity of providers should be encouraged, while taking care not to crowd out community and volunteer services.
- Innovation in service provision should be stimulated, while ensuring minimum standards of quality and access in human services.

In the BCA's view, there is not a level playing field (competitive neutrality) for the public and private sectors due to certain policies implemented by federal, state and territory governments. Competitive neutrality in service delivery is essential to providing Australians with a diversity of providers and choices that best meet their needs.[738]

As mentioned, governments will not be able to meet the expected demand and associated costs with only public delivered services. We are fortunate to have built both public and private systems, which enables those who can afford to pay to access services privately and thus increasing access to the public system for those requiring support.

Governments must leverage this mixed system and enable the full range of the private sector including charitable entities, co-ops, mutuals and typical for-profit entities the opportunity to tender for the delivery of health and care services and broaden opportunities for private sector competition. We need to recognise many community pharmacies, general practitioner and allied health practices are private providers. Appropriate guardrails and governance frameworks can be implemented to address any concerns regarding potential conflicts of interest, including consumer safety and profits.

Furthermore, existing government levers can create an anti-competitive environment, particularly for businesses. Private providers cannot provide their workers with the fringe benefits tax (FBT) exemption (from $17,000 up to $30,000) that the public and not-for-profit sectors benefit from.[739] Other government taxes such as mental health levies and COVID-19 debt levies, also create inequities.[740]

A previous PC report stated the efficient delivery of goods and services usually requires that individual providers are neither advantaged or disadvantaged by government policies or regulations, noting exemptions from input taxes can provide an advantage.[741] The *Henry Review* also outlined FBT exemptions provide providers with a competitive advantage in labour markets as they enable them to pay the market wage at a lower cost, which can be problematic for hospitals, where workforce shortages are ongoing.[742] This review suggested FBT concessions be removed and replaced with direct government funding.[743]

Governments should consider the efficiencies of these tax arrangements (such as FBT exemptions) that place private health and care providers at a competitive disadvantage relative to the full range of public providers, as these are not levied on other participants in the sector. Any such change would need to form part of a holistic review of the tax system to lift business investment and productivity.

Furthermore, the Australian Government must recognise state-based taxes and levies (COVID-19 debt levy, mental health levy, ambulance levy, payroll taxes on GPs, private patient rates in public

room, and Enterprise Bargaining Agreements) which impact the delivery of health and care services. We suggest the Australian Government address these arrangements through the ongoing NHRA negotiations.

It is important that Australia's health and care economy market supports both the private and public sectors to enable Australians to receive quality and safe care, regardless of their location or the provider.

Action 115

The Australian Government should recommit to addressing choice, competition and contestability in human services as part of the *Revitalising National Competition Policy* to ensure the effective service delivery across the public and private sectors while meeting the needs of an ageing population.

Action 116

Governments should enable the private sector (including charitable entities, co-ops, mutuals and typical for-profit entities) to tender for the delivery of health and care services and broaden opportunities for private sector competition. Appropriate guardrails and governance frameworks can be implemented to address concerns regarding potential conflicts of interest.

Action 117

Governments should consider the efficiencies of the tax arrangements (such as FBT exemptions) that place private health and care providers at various competitive disadvantages relative to the full range of public providers and among themselves. Any such change would need to form part of a holistic review of the tax system to lift business investment and productivity.

Action 118

The Australian Government must recognise state-based taxes and levies which impact the delivery of health and care services. These arrangements should be addressed through the ongoing National Health Reform Agreement negotiations.

7.6 A coordinated national approach

Recommendation 6.

Create a health and care system supported by a coordinated national approach, with improved accountability and coordination.

This strong coordinated approach will enhance governance, drive exceptional consumer outcomes and ensure the long-term sustainability of the system.

A coordinated national approach is essential to address the system's long-term structural issues. Improved accountability and coordination will require better governance and integration across the health and care economy.[744] This collaborative approach could deliver significant benefits in both cost but also productivity. This is a complex task that requires openness and collaboration among a range of stakeholders who are willing to prioritise consumer interests.

Our federated system has many strengths, but there are weaknesses, particularly a lack of coordination between governments and between the public and the private sectors. This can lead to duplicated responsibilities and services and gaps in other areas.

The ongoing division of responsibilities between the Australian Government and state and territory governments, a frequent topic in policy discussions such as the NHRA and the NDIS reforms, often leads to 'blame and cost shifting' at the expense of consumer outcomes.

To overcome this, we must view policy and reform through the lens of a consumer's life and care journey. This requires greater accountability, coordination, and transparency which will lead to better governance and integration and, in turn, deliver significant benefits for all Australians.

7.6.1 National Health and Care Economy Strategy

In 2023, the Australian Government consulted on a draft National Care and Support Economy Strategy (aged care, disability support, early childhood education and care, veterans' care) but did not finalise it.[745] Despite the establishment of a dedicated Care and Support and Aged Care Division within the Department of the Prime Minister and Cabinet, reforms are still being implemented in isolation within sub-sectors like health, aged care and disability.[746]

We believe a more holistic 'Health and Care Economy' approach encompassing health, disability and ageing, is needed to improve coordination and integration of service delivery. The Australian Government should clearly articulate and define the elements of the economy, that is, health, disability and ageing, to ensure all associated policies and reforms are fit-for-purpose. While some stakeholders believe these sectors should remain separate, and others advocate for amalgamation, there are varying views on which sectors should be combined.

We recognise there may be a broader push for the inclusion of social care and housing as this can be linked to health and care outcomes. Some countries do take this approach. However, given our federated system, our proposed approach will take time to action. Future governments may wish to consider broadening the strategy to include other sectors. We understand housing is an ongoing issue which is why we launched the *It's time to say yes to housing* report which provides key recommendations to governments to improve planning processes.[747]

Given the significant challenges we face, the Australian Government should develop a National Health and Care Economy Strategy. This strategy must provide a clear vision for all stakeholders – consumers, government, businesses and providers – as well as outlining desired outcomes and funding priorities.

It must recognise the role of both the private and public sectors, support the delivery of a sustainable economy, and ensure Australians can access the services they need, when they

need them. The strategy could also consider incorporating the proposed system performance framework proposed in the *Mid-term Review of the NHRA*.[748]

A clear and well-communicated strategy is essential for building trust and transparency between consumers, government, business, and providers. It should also serve as the foundation for any future sector-specific strategies, including those for workforce, digital health and preventative health.

Action 119

The Australian Government should clearly articulate and define the elements of the economy – specifically health, disability and ageing, and formally recognise them as the Health and Care Economy.

Action 120

The Australian Government should develop a National Health and Care Economy Strategy that provides a vision for all stakeholders: consumers, government, business, and providers.

7.6.2 Government Administration Ministerial and policy portfolios)

Australia's political and administrative structures (including the Administrative Arrangement Orders (AAOs)) significantly influence our approach to policy reform, and current arrangements likely contribute to a fragmented approach to systemic change.[749] While we welcome the Australian Government's move to publicly release the *Ministerial offices, departments of state and guide to responsibilities*, there is an opportunity to further clarify these roles and introduce key performance indicators (KPIs).[750]

With a national strategy in place, the development of KPIs for Ministers and/or government could drive greater accountability. These KPIs would ensure effective reform is undertaken, improve consumer outcomes, and hold key decision-makers to account.

To further drive accountability, we should also consider whether existing ministerial arrangements are effective in tackling the challenges of the health and care economy. International examples show different approaches to addressing health and care by amalgamating these areas.

EXAMPLE:

- **Japan:** The Ministry of Health, Labour and Welfare has five ministerial positions with specific responsibilities. This Ministry oversees policy across a range of areas, such as health and medical care, children, long-term care, employment security and labour, and pensions and welfare.[751]
- **Korea:** The Ministry of Health and Welfare has a Minister and two Vice Ministers. This Ministry coordinates and oversees health and welfare related affairs and policies.[752]
- **Norway:** The Ministry of Health and Care Services has a Minister and four State Secretaries. This Ministry is responsible for providing equitable health and care services for the entire population.[753]
- **Sweden:** The Ministry of Health and Social Affairs has four ministers with various portfolios. This Ministry is responsible for social welfare, including public health, healthcare and the care of older people.[754]

We recognise the strengths of our federated model and traditional institutions but must not allow them to hinder our ability to transform the system. Decisions made in isolation under the current arrangements can have unintended consequences on other parts of the health and care system.

We acknowledge the Australian Government's recent decision to create a Minister for Health and Ageing, and Minister for Disability and the National Insurance Scheme as a positive first step towards a more holistic view of the system.[755] The current arrangements include eight ministerial positions supported by five individuals:[756]

- Minister for Health and Ageing.
- Minister for Disability and the National Disability Insurance Scheme.
- Minister for the National Disability Insurance Scheme.
- Minister for Aged Care and Seniors.
- Assistant Minister for Mental Health and Suicide Prevention.

- Assistant Minister for Rural and Regional Health.
- Assistant Minister for Health and Aged Care.
- Assistant Minister for Indigenous Health.

We encourage the Australian Government to take this a step further and consider amending existing Ministerial portfolio arrangements to reflect the broader health and care economy and address key challenges it faces.

Australia needs to take a renewed approach to tackling health, disability and ageing. Many of these sectors face similar issues, such as workforce and funding challenges. Without a new approach, solutions implemented in isolation will not lead to better governance, integration or improved access to quality services. This proposed approach would also elevate key issues the health and care economy must address to improve its sustainability, including workforce, digital health and prevention.

Action 121

The Australian Government should consider developing and including key performance indicators to drive greater accountability, ensuring effective reform is undertaken, improve consumer outcomes, and hold key decision-makers accountable.

Action 122

The Australian Government should amend existing Ministerial portfolio arrangements to reflect the broader health and care economy and address its key challenges it faces, including workforce, prevention and digital health.

7.6.3 Australian Government Department of Health and Care Economy

Policy reform for the health and care economy is driven by various Ministers as well as departments, including the Department of Employment and Workplace Relations, the Department of Health, Disability and Ageing and the Department of Social Services. As these departments oversee different elements of the system, separate decisions can have unintended consequences. For example, there have been many instances where health and care workers have transitioned from the health and aged care sectors to the NDIS.[757]

We propose the Australian Government undertake the necessary machinery of government changes to enhance coordination and drive systemic policy reform across the health and care economy. International comparisons outlined earlier demonstrate different structures to consider in tackling health and care economy policy considerations.

By learning from international experiences, Australia could enhance accountability and coordination, improve resource allocation, improve consumer outcomes and ensure that services are delivered more effectively to meet the needs of the population.

We recognise the Australian Government's recent decision to create the Department of Health, Disability and Ageing as a positive toward a more holistic view of the system's sustainability challenges. Many reviews, including the recent *Mid-term Review of the NHRA* and the *NSW Special Commission into Healthcare Funding,* also recommended a more holistic approach to these issues.[758]

We encourage the Australian Government to take one step further and create the Department of Health and Care Economy recognising it as one system – health, disability and ageing. The Department's organisational structure should also be amended to enhance coordination and drive policy reform. A single department will support streamline policy development, implementation and reform across the health and care economy. This holistic approach would also assist in addressing the increasing burden of chronic disease and ageing population, by providing a more comprehensive understanding of consumer's journey which is usually complex and nonlinear. State and territory governments should also consider a similar approach.

Action 123

The Australian Government should create the Department of Health and Care Economy. The Department's organisational structure should also reflect the economy to enhance coordination and drive policy reform. State and territory governments should also consider adopting a similar approach.

7.6.4 Australian Health and Care Commission

We need to find a better way to work together in setting the right health and care standards and regulations, complementing the proposed ministerial and departmental changes. A range of federal are currently responsible for this, including the Australian Commission on Safety and Quality in Health Care, the NDIS Quality and Safeguards Commission, the Aged Care Quality and Safety Commission. There are also a range of state and territory bodies.

We propose the Australian Government undertake further administrative changes to drive systemic policy reform. This will support better governance and integration across the health and care economy. International comparisons also demonstrate different structures for managing the quality and safety of health and care service delivery.

EXAMPLE:

- **France:** The Haute Autorité de Santé (HAS) is responsible for a range of activities including assessment of drugs, medical devices and procedures, to the publication of guidelines and best-practice across the health and social care.[759]
- **Norway:** The National Board of Health Supervision has overall responsibility for the supervision of health and social services.[760]
- **United Kingdom:** The Care Quality Commission is an independent regulator of health and adult social care in England, covering a wide range of services. It promotes shared responsibility and nationally coordinated resources.[761]

The PC's interim report into *Delivering quality care more efficiently* suggests greater alignment in quality and safety regulation to improve efficiency and outcomes, with an initial focus on aged care, NDIS and veterans.[762] It also recommends alignment of provider accreditation, registration and audits.[763] While we recognise the broad range of sectors, reform should initially focus on health, disability and ageing. Significant work has already been undertaken in early childhood education and care and veterans' affairs.[764]

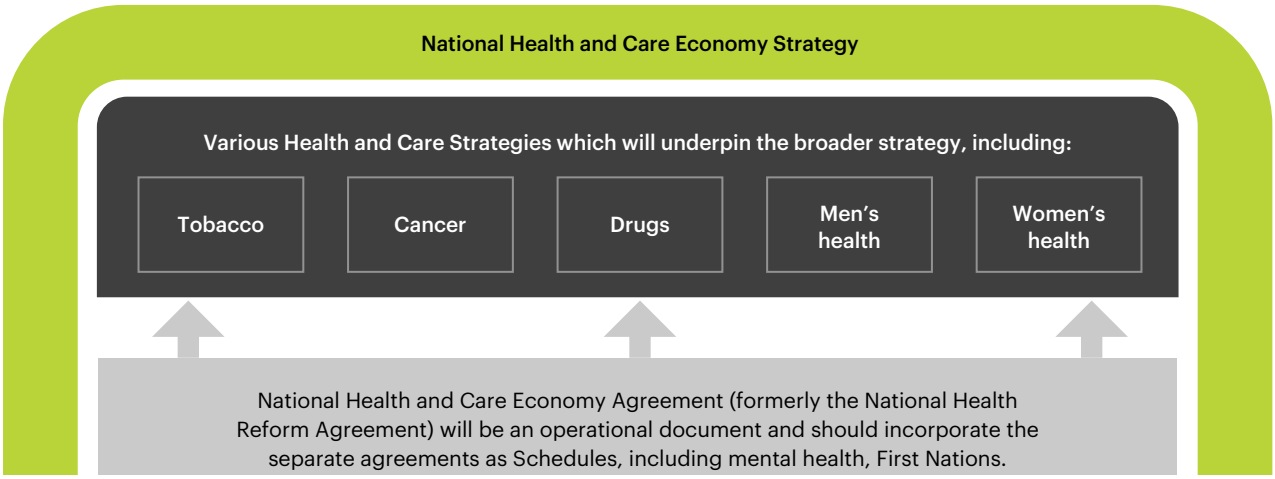
We suggest that governments in partnership with the private sector and appropriate clinical bodies consider establishing the Australian Health and Care Commission. This would amalgamate the Australian Commission on Safety and Quality in Health Care, the Aged Care Quality and Safety Commission, and the NDIS Quality and Safeguards Commission into a single Commission. The *Review into the operational effectiveness of the UK's Care Quality Commission* provides important insights for Australia to ensure the new Commission is effective.[765] Many of the review's findings could be found within our existing standalone commissions.

We do not propose amalgamating the Defence and Veterans' Service Commission, given the serious findings of the *Royal Commission into Defence and Veteran Suicide*, but we emphasise that it will need to work closely with the new Department and Commission to ensure veterans receive the care they need.[766]

We also recommend governments in partnership with the private sector and appropriate clinical bodies develop a set of National Health and Care Standards. These standards would consolidate the existing National Safety and Quality Health Services Standards (NSQHS), Aged Care Quality Standards and the NDIS Practice Standards.[767] This would be overseen by the new Commission and would streamline accreditation, audit and regulation, particularly in areas of governance and consumer engagement, while still allowing for sector-specific standards where needed. This approach would reduce confusion and complexity for consumers and providers who interact with different parts of the system.

A national and holistic approach to the health and care economy makes sense given the close connections in our health and care economy. Australians regularly move between primary care, tertiary care, aged care and disability services, and their journey is not linear. It will also support better governance and integration, while facilitating coordination by holding services to a similar standard, promoting transparency and building trust.[768] This approach would provide a more comprehensive understanding of consumer's journey, which is essential for addressing the burden of chronic disease and our ageing population.

Figure 33: Proposed hierarchy of strategic and operational documents



Action 124

Governments in partnership with the private sector and appropriate clinical bodies, should consider establishing the Australian Health and Care Commission, which would amalgamate the Australian Commission on Safety and Quality in Health Care, the Aged Care Quality and Safety Commission and the NDIS Quality and Safeguards Commission.

Action 125

Governments in partnership with the private sector and appropriate clinical bodies should develop a set of National Health and Care Standards that consolidate the existing National Safety and Quality Health Services Standards (NSQHS), Aged Care Quality Standards, and the NDIS Practice Standards.

7.6.5 National Cabinet

With overlapping responsibilities and ambiguous decision-making between different levels of government, real improvements in Australia's health and care system cannot be achieved without federated reform. Australia must continue to take a national approach to health and care challenges, and National Cabinet is the most appropriate mechanism to lead this effort.

While National Cabinet's Ministerial Council on Health and the Health Chief Executives Forum have contributed to driving health reform, more needs to be done.[769] Our proposed National Health and Care Economy Strategy will also support and underpin this approach.

For this reason, National Cabinet should establish a specific taskforce or use the Ministerial Council on Health to identify and remove duplication, inefficiencies and overlap in health and care service delivery between federal, state and territory governments. The *Unleashing the Potential of our Health Workforce Scope of Practice Review – Final Review* and the current PC interim report into *Delivering quality care more efficiently* both highlight areas of potential overlap and inefficiencies.[770] The *Mid-term Review of the NHRA* also raises issues with joint planning and commissioning that could be addressed as part of these discussions.[771]A 12-month plan should be made publicly available, and the private sector should be consulted on this work.

We also urge National Cabinet to address the recommendations of the *Mid-term Review of the NHRA* and ensure they are reflected in the NHRA currently being negotiated, as well as in ongoing aged care and NDIS reforms. We recommend the new agreement should be named the National Health and Care Economy Agreement.

The *Mid-term Review of the NHRA* recommended that the NHRA be framed as a single collaborative

health system agreement, with a shared vision, framework and objectives.[772] It also suggested other existing agreements be amalgamated as schedules, such as mental health and First Nations.[773] As such, we also recommend National Cabinet address this to streamline bureaucratic processes. The proposed structure below should be considered to frame Australia's approach moving forward (refer to figure 33).

National Cabinet should empower the proposed Australian Health and Care Commission or the Australian Health and Care Planning and Delivery Agency with accountability and responsibility to implement any initiatives listed in the new agreement. History has demonstrated once the NHRA has been finalised, reform progress is often limited.[774] This addresses another recommendation of the *Mid-term Review of the NHRA* which proposed a National Innovation and Reform Agency.[775]

We are not of the view that a separate National Innovation and Reform Agency should be established. Existing governance structures and institutions should be reviewed, combined and focused, where appropriate. Therefore, the proposed Australian Health and Care Commission or the Australian Health and Care Planning and Delivery Agency would be the most appropriate body to drive reform.

Action 126

National Cabinet should establish a specific taskforce or use the Ministerial Council on Health to identify and remove duplication, inefficiencies and overlap in health and care service delivery between federal, state and territory governments. A 12-month plan should be made publicly available, and the private sector should be consulted on this work.

Action 127

National Cabinet should address the recommendations of the *Mid-term Review of the National Health Reform Agreement* and ensure they are reflected in the new agreement, as well as in ongoing aged care reforms, and NDIS reforms. This new agreement should be named the National Health and Care Economy Agreement.

Action 128

National Cabinet should amalgamate other existing agreements as schedules to the National Health and Care Economy Agreement, such as mental health and First Nations.

Action 129

National Cabinet should empower the proposed Australian Health and Care Commission or the Australian Health and Care Planning and Delivery Agency with the accountability and responsibility to implement any initiatives in the National Health and Care Economy Agreement.

7.6.6 Legislation and Regulations

Federal, state and territory governments in liaison with the private sector and clinical bodies, should seek to harmonise legislation and regulation in areas such as drugs and mental health. This will reduce the administrative and regulatory burden on providers, drive productivity and enable greater workforce flexibility without compromising quality and safety standards.[776] This would also make it easier for national or cross-jurisdictional providers to operate. For example, state and territory governments are at different stages of rolling out pilots to expand the scopes of practice for pharmacists.[777]

National Cabinet has had some success with occupational licensing requirements.[778] Such consistency will enable health and care workers to spend more time with consumers. This should be addressed in line with the findings of the *Unleashing the Potential of our Health Workforce Scope of Practice Review – Final Report*.[779] The PC's interim report into *Delivering quality care more efficiently* also suggests aligning worker regulation to improve efficiency and outcomes.[780]

The recent changes to aged care highlight that reforming the health and care economy can be complex with much of the detailed implementation outlined in legislative instruments.[781] While it would be impractical to place this detail in legislation, it can provide a degree of flexibility. However, the consequences mean that it can add greater complexity for providers delivering the services.

EXAMPLE:

- **Uncertainty:** Recent reforms to aged care due to commence 1 July 2025 were dependent on legislative instruments that, as of May 2025, had not been tabled or consulted on. This lack of clarity makes it difficult for aged care providers to comply and for consumers to understand the implications.

All governments should commit to genuinely consulting and working with the health and care providers to allow adequate time for regulatory changs to be implemented. Effectively engaging with stakeholders in the process will ensure regulations are efficiently introduced, driving productivity. Ineffective implementation undermines good reform with the potential benefit not realised or additional costs incurred to meet unrealistic requirements.

A joined-up health and care economy system with well-calibrated regulation will deliver the best value, improve quality of care and increase productivity. Greater clarity around the spectrum of health and care services will maximise efficiency, simplify access and minimise arbitrage.

Action 130

Governments, in liaison with the private sector and clinical bodies, should seek to harmonise legislation and regulation in areas such as drugs and mental health. This will reduce administrative and regulatory burden on providers and workers, and drive productivity.

Action 131

All governments should genuinely commit to consulting with health and care providers to allow adequate time for regulatory changes to be implemented.

7.6.7 Clinical Guidelines and Standards

Given the introduction of new technology and models of care, Australia should continue to strive for world-leading clinical standards. The goal should be to have evidence-based guidelines that outline best practice and reduce unwarranted variation in clinical care.[782] This would reduce costs, increase consumer safety and improve consumer experience.[783] It may also reduce the need for individual providers to develop policies and procedures at a local level.

There are international examples that demonstrate the ability to drive change nationally. Overseas models will need to be adapted to Australia's unique health and care context. We recognise overseas models have limitations and should be carefully considered before implementation.

EXAMPLE:

- **United Kingdom:** In England and Wales, the National Institute for Health and Care Excellence (NICE) guidelines are evidence-based recommendations for health and care.[784]
- **France:** In France, the Haute Autorité de Santé (HAS) develops recommendations for professionals of both health and social care sectors to optimise and harmonise practices and organisations of care.[785]

We recognise that the NHMRC provides guidelines and standards for healthcare practice, focusing on evidence-based recommendations.[786] The Australian Living Evidence Collaboration is another example of delivering up-to-date evidence and guidelines.[787] We suggest National Cabinet identify a national body to oversee the development and implementation of national clinical guidelines and determine how guidelines can be more broadly shared and adopted. National Cabinet may wish to consider overseas models.

This supports a recommendation from the *Mid-term Review of the NHRA* to develop optimal models of care.[788] The funding pathway for these models could be supported by an appropriate body, such as the proposed Australian Health and Care Commission or the Australian Health and Care Pricing Authority.

Alternatively, we suggest National Cabinet in partnership with the private sector, industry and appropriate clinical bodies, consider developing national clinical collaboratives. Industry representation, such as the pharmaceutical industry will be important as they can bring valuable expertise on innovative treatments and

evidence that would inform the development of guidelines. This work should also involve the Australian Health and Care Economy Commission. We do not propose limiting providers from developing local work guidelines, but these collaboratives would improve care standards and reduce unwarranted variations in clinical care.

EXAMPLE:

- **Collaboratives:** The Paediatric Improvement Collaborative was formed in 2018 between Clinical Excellence Queensland, the NSW Agency for Clinical Innovation, Safer Care Victoria, and the Royal Children's Hospital Melbourne. In 2023, South Australia's Women's and Children's Health Network became a partner. Other states and territories have expressed interest, and in the coming years, aims to become a national body and produce Australian Paediatric Clinical Practice Guidelines.[789]

This is an enormous task, and collaboratives may be more appealing than a national body or overseas models. It has been done in paediatrics. The success of the paediatric collaborative demonstrates this approach is feasible. Supported by appropriate governance structures, this would drive better governance and integration, influencing clinical standards and models of care with the appropriate clinical input.

It will be important to incorporate mechanisms that ensure timely reviews and updates to address new evidence and innovations as well as prevent consumer delays accessing breakthrough treatments. Consideration should be given for an impact assessment process that evaluates how proposed guidelines might affect the system, including research investment and innovation pathways.

We recognise the need to maintain appropriate flexibility to accommodate personalised medicine approaches and consumer-specific needs, particularly for rare diseases and complex conditions. However, we should strive towards best practice.

Furthermore, we are fortunate to have the *Australian Atlas of Healthcare Variation Series* which examines a series of topics, investigates variation and the possible reasons for it, and provides specific achievable actions to reduce unwarranted variation.[790] The fourth edition was released in 2021 and examines variation in 17 healthcare items.[791] We suggest the Australian Government provide dedicated funding to enhance the adoption of the *Australian Atlas of Healthcare Variation Series*. This will support raising awareness of, and access to services that produce better outcomes.

Currently, the Atlas is underutilised but there is opportunity for it to be used more effectively to support best practice. It could also be used to guide future investment to improve access to services. Consideration of other complementary systems to those identifying unwarranted variation may be needed. This work should involve the proposed Australian Health and Care Commission.

Action 132

National Cabinet should identify a national body to oversee the development and implementation of national clinical guidelines and determine how guidelines can be more broadly shared or adopted. National Cabinet may wish to consider overseas models.

Action 133

National Cabinet, in partnership with the private sector, industry and clinical bodies, should consider developing national clinical collaboratives (such as the Paediatric Improvement Collaborative). This should involve the proposed Australian Health and Care Commission.

Action 134

The Australian Government should provide dedicated funding to enhance the adoption of the *Australian Atlas of Healthcare Variation Series*. This will support raising awareness of, and access to services that produce better outcomes. This work should involve the proposed Australian Health and Care Economy Commission.

7.6.8 Government Budget and Policy Processes

A concerted effort is needed to introduce initiatives that have the best chance of improving the health and wellbeing of Australians. Current government processes often limit support for initiatives whose benefits may not be fully realised in the short term. Short-term initiatives that lend themselves to ribbon-cutting announcements may be more appealing to governments, but to successfully overcome our health and care challenges, the longer-term perspective is essential.

Governments must take a long-term approach to the delivery of health and care services. Governments generally only consider the forward estimates, which typically covers the next three years. We recognise the Australian Government's investment of $588.5 million over eight years from 2024-25 and $113.4 million per year ongoing for a new national early intervention service providing free digital mental health support.[792]

All governments should amend their existing government internal processes, including budget and new policy proposal processes, to ensure consideration of the long-term impacts of health and care investments. This is particularly important for more sustainable initiatives like preventative and digital health programs, whose true benefits may take years to materialise, making their immediate expense difficult to justify beyond the forward estimates.[793]

Given the complexity of Australia's health and care system, all governments should receive informed evidence from across departments. This includes better advice on the potential impacts of the population's health and wellbeing and the broader system. Clarity should also be provided on how governments will address risk. The use of existing processes such as Regulatory Impact Statements could support this. This informed evidence and advice should be made public when a new policy is announced to provide justification to all stakeholders.

Furthermore, the Parliamentary Budget Office prepares many policy costings for parliamentarians which estimate the impact of the proposed policies on the Australian Government Budget.[794] These costings include the static and direct behavioural impact of proposals; however, they do not include quantitative estimates of broader economic effects.[795] A key reason cited for this approach is the challenges associated with estimating such impacts, with many much smaller in magnitude than the direct impact.[796]

We suggest the Parliamentary Budget Office should amend their costings process to include broader economic effects for health and care proposals. This will ensure the longer-term benefits for preventative and digital measures are considered and incorporated. This may also require the Australian Government to update the *Charter of Budget Honesty Policy Costing Guidelines*.[797]

These recommendations are supported by the *NSW Special Commission into Healthcare Funding* which provided two key recommendations that address issues with government budgets and processes.[798] It is clear a new approach is needed to consider the overall health and productivity of the nation.

Action 135

All governments should amend existing government internal processes, including budget and new policy proposal processes, to ensure consideration of the longer-term impacts of health and care investments. This includes implementing more sustainable initiatives like preventative health programs.

Action 136

All governments should receive informed evidence across departments on the potential impacts of new policies or initiatives on the population and the broader system. This advice should be made public, once a new policy is announced.

Action 137

The Parliamentary Budget Office should amend the costings process to include broader economic effects for health and care proposals. This will ensure the longer-term benefits for initiatives such as preventative and digital are considered and incorporated.

7.6.9 Evaluation of policies and programs

It is important for policymakers and governments to understand the positive and negative impacts of significant health and care reforms, and whether they are meeting their objectives. The evaluation of policies and programs can also inform future policy development and decisions.

We recognise the *Commonwealth Evaluation Policy*, launched in 2021, which aims to embed a culture of evaluation to underpin evidence-based policy and delivery.[799] Several Australian Government initiatives, which have significant tax-payer funds tied to them, should be evaluated.

The *Capability Review* of the Department of Health and Aged Care found nine priority areas for improvement, including:[800]

- integrated strategic policy development capabilities
- using data to inform policy
- systemic consideration of the health and aged care workforce
- increased knowledge about the providers the department funds and regulates
- readiness for future healthcare delivery
- learning the lessons from COVID-19
- collaborative and enduring relationships with the states and territories
- improved communication and engagement with the community
- building and empowering the mid-level of the department.

It is clear the public service needs to improve how it evaluates programs that involve substantial taxpayer funding. The Australian Centre for Evaluation was established to help embed evaluation evidence at the heart of policy design and decision-making.[801]

It will also be important investment is made to enable data linkage and assets to support such evaluations.[802] We recognise the work being done by the Australian Institute of Health and Welfare via the National Health Data Hub which is a national de-identified linked data system drawing together core government datasets.[803] The Australian Government should further leverage the National Health Data Hub to enable the better use of data being collected and used to support the evaluation of initiatives.

Considering the Capability Review and the role of the Australian Centre for Evaluation, we recommend that the Department of Health, Disability and Ageing effectively implement the *Evaluation Strategy 2023-26* in partnership with the Australian Centre for Evaluation. This will ensure significant policies and programs are effectively addressing the needs of all Australians, while analysing value for money, consumer benefits and unintended consequences.

The Department's *Evaluation Strategy* aims to provide a framework to strengthen policy and program evaluation as well as increase the use of evaluation evidence for decision-making.[804] However, the onus sits with the division to fund and conduct evaluations of their policies and programs, and the rolling schedule of evaluations is not public.[805] We recommend the Department of Health, Disability and Ageing make the rolling schedule of evaluations public under its *Evaluation Strategy* to provide greater transparency on evaluations being undertaken. This will provide certainty to stakeholders as to which programs and policies are scheduled for evaluation.

Given that some policies and programs run for many years or are ongoing, we suggest the *Evaluation Strategy* include evaluations every three to five years for these policies and programs to ensure they remain effective and deliver on their intended outcomes. This recognises that the health and care landscape, including models of care, continues to change due to innovations and new technology.

A robust evaluation framework will help ensure significant policies and programs meet their required objectives, which is essential given the sustainability challenges of the health and care system and the finite resources.

Action 138

The Australian Government should further leverage the National Health Data Hub to enable the better use of data being collected and used to support the evaluation of initiatives.

Action 139

The Department of Health, Disability and Ageing should effectively implement the *Evaluation Strategy 2023-26* in partnership with the Australian Centre for Evaluation to ensure significant policies and programs effectively address the needs of Australians, analysing value for money, consumer benefits, and unintended consequences. The rolling schedule should be made public.

Action 140

Evaluation Strategy 2023-26 must include evaluations every three to five years for ongoing policies and programs to ensure they remain effective and deliver their intended outcomes. This recognises the evolving landscape, including changing models of care due to innovations and new technology.

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Appendices

BCA
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Appendix 1 – Responsibilities

Level of government	Responsibility
Federal	■ Sets national policy, including aged care, workforce, funding arrangements, private health ■ Responsible for Medicare, including Medicare Benefits Schedule, Pharmaceutical Benefits Scheme ■ Funds research such as the Medical Research Future Fund, National Health and Medical Research Council, university research
State and territory	■ Manages public hospitals ■ Licences private hospitals ■ Manages workforce ■ Responsible for public community-based and primary health services ■ Delivers preventative services ■ Responsible for ambulance services ■ Handles health complaints ■ Supports research
Local	■ Provides environment health-related services ■ Delivers some community and home-based services ■ Delivers some public health and health promotion activities
Private	■ Delivers a range of services, including health, medical, pharmaceutical, technology, research

Appendix 2 – Actions

Actions	By 2028 within 3 years	By 2030 within 5 years	By 2035 within 10 years
Action 1 The Australian Government should finalise and release the National Health Literacy Strategy with an accompanying action plan to outline how Australia will improve the health literacy of its population.	●		
Action 2 Governments should undertake targeted education and communication campaigns to support consumers better understand their health needs, and are motivated to take preventative action. This also includes when they do need care, are aware of the available options, and know how to access services. Governments should focus on priority populations to have greater impact.		●	
Action 3 Governments and providers should empower consumers to choose their own services by increasing transparency on price, performance, treatment options, and expected outcomes as well as improving consumer experiences.	●		
Action 4 Governments should work with the proposed Australian Health and Care Commission and peak consumer groups to evaluate and monitor consumer engagement and transparency reforms. This will ensure the Australian health and care system embeds evidence-based principles and processes to empower consumers.		●	
Action 5 The Australian Government should comprehensively respond to the outstanding consultations from 2022 and 2023 on risk equalisation, private health insurance incentives, and hospital default benefits.	●		
Action 6 The Australian Government should task Treasury or the Productivity Commission to undertake a whole-of-system economic analysis on the range of health and care funding levers to ensure intergenerational fairness and the system remains sustainable.	●		

Actions	By 2028 within 3 years	By 2030 within 5 years	By 2035 within 10 years
Action 7 The Australian Government should establish the Australian Health and Care Planning and Delivery Agency to provide independent advice on the planning and delivery of health and care services.		●	
Action 8 The Australian Government should rename the existing Independent Health and Aged Care Pricing Authority to the Australian Health and Care Pricing Authority and expand its remit to provide independent and transparent advice on pricing for services across health, disability and ageing.	●		
Action 9 The Australian Government may wish to provide the Australian Health and Care Pricing Authority with responsibility to assess and approve annual private health insurance premiums.		●	
Action 10 National Cabinet should agree to the Australian Institute of Health and Welfare to undertake a strategic review of current reporting requirements and data repositories to identify gaps and redundancies.	●		
Action 11 The Australian Government should consider the Productivity Commission's interim findings into *Delivering quality care more efficiently* for collaborative commissioning in its *Review of Primary Health Network Business Model and Mental Health Flexible Funding Model* to determine whether the right operating model is in place to support a whole-of-system approach.	●		
Action 12 In time, the Australian Government should transition away from Primary Health Networks and provide the responsibility for commissioning services to a new entity such as the proposed Australian Health and Care Economy Planning and Delivery Agency. This would reduce bureaucracy and provide greater responsibility to state-led services.			●
Action 13 The Australian Government should consider the following as part of the next evaluation of Urgent Care Clinics (UCCs): cost comparisons of UCCs versus emergency departments and community-led GP practices, and whether UCCs can be expanded to provide a broader range of community-led services.	●		

Actions	By 2028 within 3 years	By 2030 within 5 years	By 2035 within 10 years
Action 14 The Australian Government should evaluate the effectiveness of increasing the bulk-billing rate for 16-64 years-olds, 12 months after its implementation, to determine if the increased rate was applied to the right types of consultations.	●		
Action 15 The Australian Government should first conduct an independent and formal evaluation of the 2019-20 private health insurance reforms, including product design and coverage.	●		
Action 16 The Australian Government must ensure that any proposals or solutions address the issues identified in the Private Hospital Sector Financial Check and continue to respond to its findings.	●		
Action 17 The Australian Government needs to undertake a detailed assessment of mental health and maternity services to model the potential financial impacts of any proposed changes on consumers, insurers and hospitals before making substantial reforms, particularly in regional, rural, and remote areas in both the public and private settings.	●		
Action 18 The Australian Government should review the *Private Health Insurance Act 2007* (Cth) to determine whether the legislation is still fit-for-purpose, given the changing disease profile and ageing population.		●	
Action 19 The Australian Government should consider measures to improve transparency and efficiency in private health by: ■ Streamlining government regulation and legislative requirements for the private sector. ■ Enhancing technology interoperability across the sector, including the ECLIPSE system. ■ Expanding the Independent Health and Aged Care Authority's Private Hospital Costing Dataset Collection to include all private hospitals. ■ Considering the development of a My Private Hospital Portal to provide consumers with more information, including pricing. ■ Publicly releasing the number of Australians holding specific levels of private health insurance cover as part of quarterly updates.		●	

Actions	By 2028 within 3 years	By 2030 within 5 years	By 2035 within 10 years
Action 20 The Australian Government should assign responsibilities related to private health to either the proposed Australian Health and Care Pricing Authority, the Australian Health and Care Commission or the Australian Health and Care Planning and Delivery Agency. Specific roles can be determined through extensive consultation.		●	
Action 21 An economic analysis must be undertaken to determine whether a National Private Price or National Private Weighted Average Unit is feasible for private health before implementation. The analysis needs to recognise the differing funding structures compared to the public system as well as the cost differences between for-profit and not-fo-profit providers.		●	
Action 22 The Australian Government should provide incentive payments to state and territory governments through the National Health Reform Agreement for the utilisation of private capacity for consumers who have exceeded the clinically approved wait time for elective surgery.	●		
Action 23 The proposed Australian Health and Care Planning and Delivery Agency play a stewardship role in supporting better coordination, planning and delivery of services across health, disability and ageing.		●	
Action 24 The Australian Government should utilise the proposed Digital Health and Care Interoperability Fund to support the enhancement of digital systems within the aged care system.	●		
Action 25 All governments should address the recommendations of the BCA's report, *It's time to say yes to housing*, which recommends planning approval changes to expedite projects. All governments should address these recommendations, including to prioritise residential aged care facilities and workforce accommodation, particularly in regional areas.	●		
Action 26 The Australian Government should explore other ways for those who have the capacity to pay, to fund their aged care through a greater variety of financial products.			●

Actions	By 2028 within 3 years	By 2030 within 5 years	By 2035 within 10 years
Action 27 The Australian Government should work with industry to determine insurance benefit designs, including annuity solutions, that could supplement the income needs of Australians and support the government's growing aged care funding challenge.			●
Action 28 Governments should support and scale proven new models of care, including hospital-in-the-home, and associated funding arrangements across the health and care system. These should be clinically appropriate, improve access, quality and experience.		●	
Action 29 The Australian Government may wish to provide the proposed Australian Health and Care Commission and the proposed Australian Health and Care Planning and Delivery Agency with the responsibilities to accredit new models of care and determine where these services are needed.		●	
Action 30 The Australian Government, in partnership with clinical bodies, needs to develop robust virtual care standards to ensure the safety and quality of services and support their broader uptake	●		
Action 31 The Australian Government should incentivise state and territory governments to utilise virtual health, including telehealth and remote monitoring, more effectively for high-cost hospital care, reducing demand for inpatient services. This could be addressed through the National Health Reform Agreement.	●		
Action 32 The Australian Government should develop sustainable funding incentives for telehealth and remote monitoring services to support their provision across the broader health and care economy without impacting delivery of face-to-face services.	●		
Action 33 Governments and providers should prioritise quality over quantity of services in government funding models, including the move to blended or capitated funding for service provision in primary and tertiary care.		●	

Actions	By 2028 within 3 years	By 2030 within 5 years	By 2035 within 10 years
Action 34 The Australian Government may wish to consider other mechanisms to address out-of-pocket expenses. Consideration may also be given to alternative models of care that give Australians access to services.		●	
Action 35 The Australian Government should introduce legislation to parliament as a priority to ban the use of adverse genetic testing results in life insurance. This will prevent lifetime insurers to discriminate against an individual based on their genomic testing findings.	●		
Action 36 Governments should work with industry, unions and research providers to create a National Centre for Workplace Mental Health and Wellbeing to unlock expertise, pool resources and drive the implementation of solutions.	●		
Action 37 The Australian Government should provide responsibility for the National Workplace Initiative to the proposed National Centre for Workplace Mental Health and Wellbeing.		●	
Action 38 The Australian Government should transfer the roles and responsibilities of the National Mental Health Commission to the Australian Centre for Disease Control, as mental health is a chronic condition. Alternatively, the government should consider re-formalising the National Mental Health Commission as a separate entity to the Department of Health, Disability and Ageing.	●		
Action 39 The Australian Government will need to ensure the new national digital health initiative reduces fragmentation within the mental health system to ensure Australians can access the services they require.	●		
Action 40 The Australian Government should consider whether there are legislative barriers under the *Private Health Insurance Act 2007* (Cth) which should be removed to allow private health insurers to fund hospital-substitute care and expand their ability to fund out-of-hospital care, particularly in mental health.		●	

Actions	By 2028 within 3 years	By 2030 within 5 years	By 2035 within 10 years
Action 41 The Australian Government should expand the role of primary care, including general practices and mental health nurses, through blended funding models to provide accessible mental health services for consumers.		●	
Action 42 The Australian Government should examine expanding MBS incentives to help Australians to access private mental health services.	●		
Action 43 Incentivise the provision of health and care services in difficult-to-service areas, with a focus on evidence-based practices, training an appropriate workforce and the utilisation of telehealth.	●		
Action 44 Provide digital infrastructure, such as faster internet connections and telehealth capabilities to enable greater access to specialist services without the need to travel, noting this will require broader government support.		●	
Action 45 Enable new funding models that support the flexible movement of health and care workers to provide better access to care in remote, rural and regional areas. This could include specific regional hub and spoke models to deliver necessary services.		●	
Action 46 Make targeted investments and co-design with Indigenous Australians to address Closing the Gap goals. This should include greater uptake of chronic disease care plans and improved access to specialist services.	●		
Action 47 Enable Aboriginal Community Controlled Health Organisations (ACCHOs) to deliver a wider range of services and provide additional funding for education.	●		
Action 48 Governments should consider the BCA's The big five questions and recommendations from its *Australia's flagging productivity and international* competitiveness report to increase productivity across the economy, including the health and care sectors.	●		

Actions	By 2028 within 3 years	By 2030 within 5 years	By 2035 within 10 years
Action 49 All governments should ensure the findings from the Productivity Commission's *Delivering quality care more efficiently* interim report are considered as part of the current National Health Reform Agreement and National Disability Insurance Scheme negotiations.	●		
Action 50 The Australian Government should consider the Productivity Commission's previous reports and recommendations on the health and care economy, including digital health and mental health.		●	
Action 51 The Productivity Commission should consider existing health and care economy reports and associated recommendations to incorporate into the final report, such as digital health.	●		
Action 52 The Australian Government should expedite the establishment of the Australian Centre for Disease Control to address the findings of the *COVID-19 Response Inquiry Report*.	●		
Action 53 The Australian Government should expand the role of the Australian Centre for Disease Control to include prevention. This would follow a similar approach to international comparisons. Consideration should also be given to the Australian Prevention Partnership Centre which is already funded by various governments and not-for-profit partners.	●		
Action 54 National Cabinet must ensure prevention activities are a priority and set out in the updated National Health Reform Agreement, complementing the National Preventative Health Strategy, and the work of the Australian Centre for Disease Control.	●		
Action 55 All governments should commit to increasing health expenditure for preventative health measures to five per cent by 2030 as a first step to align with the OECD average. These measures should be cost effective and evidence based. Consideration may be given to the establishment of a National Prevention Investment Fund.		●	

Actions	By 2028 within 3 years	By 2030 within 5 years	By 2035 within 10 years
Action 56 The Australian Government should consider developing a preventative health framework to support the implementation of the *National Preventative Health Strategy*. This should also include an evaluation framework. This national framework would provide the key foundations and measures to ensure the long-term benefits of preventative measures are recognised.		●	
Action 57 Governments should target investment in preventative measures with a particular focus on the leading cause of disease, including mental health, cardiovascular disease and obesity. These measures should be cost effective, and evidence based.		●	
Action 58 Governments should consider a range of specific preventative health initiatives and measures to improve the health of the population, such as awareness campaigns, education and training, and early intervention. Governments should focus on priority populations such as First Nations people, those with lower socioeconomic status and people with disability to have greater impact.		●	
Action 59 Governments should work with universities to develop and expand low-cost, student-led preventative health and care service models on campus. These models would provide access to early intervention and preventative services while supporting health and care students to gain experience to become qualified health and care workers.		●	
Action 60 The Australian Government should implement routine hearing screening every 1-3 years for adults aged 50 and over, led by GPs and integrated into chronic disease assessments to improve hearing outcomes. This should be supported by clear referral pathways to audiology and hearing rehabilitation services. Nationally consistent cochlear implant referral criteria should also be embedded across both the public and private sectors.		●	
Action 61 Increase public funding caps for cochlear implants to ensure early and timely access for older adults, helping to reduce waiting times, improve hearing outcomes, and lower dementia risk through early intervention.	●		

Actions	By 2028 within 3 years	By 2030 within 5 years	By 2035 within 10 years
Action 62 Governments should consider incentivising and improving processes that would effectively allow for the identification of cross-portfolio issues and for initiatives to be brought forward by several Ministers. This would enable governments to tackle issues before they become health problems.	●		
Action 63 The Australian Government should rename the Australian Digital Health Agency to the Australian Digital Health and Care Agency with an expanded remit to oversee digital transformation across aged care and disability. This will ensure a more holistic approach to digital transformation is considered.			●
Action 64 The Australian Government should expand and mandate the *National Healthcare Interoperability Plan 2023-2028* and related standards to the entire health and care economy, including aged care and disability, in parallel with privacy considerations.		●	
Action 65 The Australian Government should establish a public register of health and care software that can be integrated with My Health Record to help providers invest in interoperable systems. Incentives for developers should also be considered.	●		
Action 66 The Australian Government should consider expanding and mandating the *National Healthcare Identifiers Roadmap 2023-2028* across the health and care system for greater system interoperability – including health, aged care and disability within the public and private sectors.		●	
Action 67 All stakeholders should play an active role in enabling the settings to allow for the development and use of consumer technological solutions, subject to privacy and security standards. It will be important that consumers have control over their data.		●	
Action 68 The Australian Government should continue to invest in and review regulatory barriers to use My Health Record and its supporting architecture so that it is easier to access and share information.	●		

Actions	By 2028 within 3 years	By 2030 within 5 years	By 2035 within 10 years
Action 69 The Australian Government should consider how My Health Record, the Aged Care Portal, the NDIS myplace portal and the Carer Gateway can become interoperable, subject to confidentiality and privacy considerations.		●	
Action 70 The Australian Government should explore a range of assistance models, including private sector-led partnerships. For example, the introduction of a Digital Health and Care Interoperability Incentive Fund could support the digitisation of paper-based records and interoperability across the health and care system.	●		
Action 71 Governments should ensure our standards and regulatory framework align with international counterparts so Australians can access the latest medicines and technology. This includes reviewing and considering where regulation can be better aligned and reduce unnecessary duplication.		●	
Action 72 The Australian Government should aim for greater consistency by streamlining and reducing duplicative processes for medical technology and medicine listing, while maintaining clinical and consumer safety. Governments should consider an 'tell us once' approach.	●		
Action 73 Governments should clearly outline a vision for the future use of medical technology and medicines in Australia, with supporting policies to enable Australian companies to remain onshore. Funding incentives for medical technology and medicines should be aligned to provide Australians with access to new technology and medicines.	●		
Action 74 The Australian Government should implement the recommendations of the *Health Technology Assessment Policy and Methods Review Final Report* as an urgent priority to ensure Australians can access medical technology and medicines in a timely manner. Priority consideration should be given to the discount rate and comparator criteria.	●		

Actions	By 2028 within 3 years	By 2030 within 5 years	By 2035 within 10 years
Action 75 The Australian Government should commit to increasing research and development spend, with an aspirational goal of 3 per cent of GDP.		●	
Action 76 Governments should action the recommendations in the BCA's *Unlocking Australia's R&D potential* report to ensure Australia is globally recognised to invest in and undertake research.	●		
Action 77 The Australian Government should expedite the development of a National Health and Medical Research Strategy to provide certainty to researchers. This strategy should address the commercialisation of research and scaling new models of care.	●		
Action 78 Governments should provide stronger incentives and better coordination for research and development between industry, universities and government.	●		
Action 79 The Australian Government needs to better explain and build confidence in the Research and Development Tax Incentive policy to ensure Australia remains a leading destination for research and development.	●		
Action 80 The Australian Government should abolish the research and development expenditure threshold or, at a minimum, raise it to $250 million with indexation to attract greater investment.	●		
Action 81 The Australian Government should introduce a collaboration premium of up to 20 per cent on non-refundable tax offsets to incentivise partnerships between industry, public research organisations and universities.		●	
Action 82 Governments should action the recommendations in the BCA's *Accelerating Australia's AI Agenda* report to ensure Australia is a globally recognised AI leader by 2028, supporting productivity	●		

Actions	By 2028 within 3 years	By 2030 within 5 years	By 2035 within 10 years
Action 83 The Australian Government should consider as a priority the findings of the Therapeutic Goods Administration and the Department of Health, Disability and Ageing on the uptake and use of AI.	●		
Action 84 The Australian Government needs to provide clear guidance on the role the Therapeutic Goods Administration will play in regulating AI as it is the regulatory body for clinical and medical devices. Our approach cannot undermine providers' ability to safely and responsibly develop or deploy AI systems.	●		
Action 85 Collaboration between industry and government will be crucial and the use of sandbox models should be considered to enable the trial and use of AI technologies before scaling up. This will provide a safe environment.	●		
Action 86 All stakeholders, including governments, unions and providers need to increase flexibility and remove rigidity in workplace laws to support innovation, productivity, operational requirements and workers' preferences.		●	
Action 87 All stakeholders need to limit rigid regulatory conditions and standards that do not necessarily increase the quality of care, as these can hinder productivity, limit workforce flexibility and mobility, and inhibit new models of care.		●	
Action 88 The Australian Government must acknowledge the cost pressures from wages increases, particularly the impact on the sustainability of private hospitals and private health insurance.	●		
Action 89 Awards should be simplified and modernised to make them easier to navigate and apply across the health and care system.	●		
Action 90 The Australian Government should take a whole-of-system approach to workforce planning and delivery across the health, disability and ageing. The Department of Health, Disability and Ageing should create an overarching Workforce Division and amalgamate existing siloed workforce areas.		●	

Actions	By 2028 within 3 years	By 2030 within 5 years	By 2035 within 10 years
Action 91 All stakeholders should seek to strengthen workforce data and reporting requirements to enable a national approach that can easily identify demand, supply and potential gaps.	●		
Action 92 The proposed Australian Health and Care Planning and Delivery Agency or the proposed Australian Health and Care Commission should release biannual reports on future workforce needs. This should be done in consultation with the proposed Australian Health and Care Practitioner Regulation Agency and education providers.		●	
Action 93 National Cabinet, in consultation with clinical bodies and providers, should rename the Australian Health Practitioner Regulation Agency to the Australian Health and Care Practitioner Regulation Agency with an expanded remit to oversee the broader health and care workforce.		●	
Action 94 Governments, clinical bodies, unions and providers should review existing job designs and ensure these are still fit-for-purpose and relevant given the changing nature of the system, including the use of technology and new models of care.	●		
Action 95 Governments should implement the findings of the *Unleashing the Potential of our Health Workforce Scope of Practice Review – Final Report* to enable health and care workers to work to their full scope of practice and provide multidisciplinary care.	●		
Action 96 All governments should consider the findings of the *Unleashing the Potential of our Health Workforce Scope of Practice Review – Final Report* to consider applying these findings to other settings, including aged and tertiary care, with appropriate clinical governance and standards.		●	
Action 97 The Australian Government should action the findings of the *MBS Review Advisory Committee Surgical Assistants Final Report November 2022* and introduce Medicare Benefits Schedule (MBS) items for nurse practitioner surgical assistants in private practice to provide greater access to services, reduce workforce shortages and better use skilled workers.	●		

Actions	By 2028 within 3 years	By 2030 within 5 years	By 2035 within 10 years
Action 98 The Australian Government should undertake a review to determine whether nurse practitioners and other health and care workers such as paramedics can play a more active role across a broader range of services to help address workforce challenges.		●	
Action 99 Government, clinical bodies, education providers and health and care providers should ensure education and training courses incorporate new models of care and leading burdens of disease, such as dementia, digital technology, AI and genomics. All stakeholders must ensure their courses prepare students to be workforce ready.		●	
Action 100 Governments and education providers should work towards greater harmonisation and mobility of qualifications to allow students to alter their study interests while receiving credit for any completed study.		●	
Action 101 The Australian Government and education providers should review and adjust the number of commonwealth-funded and VET placements for health and care workers where gaps have been identified, including medicine, nursing and allied health. Postgraduate studies should also be considered to support upskilling.	●		
Action 102 The Australian Government should consider expanding the Commonwealth Prac Payment to roles where gaps appear, such as occupational therapists and speech pathologists. It will be important to maintain means testing and review periodically to ensure the right people are receiving support.		●	
Action 103 Government, business and the tertiary sector should be incentivised, through targeted funding to develop microcredentials to lift skills, enhance career progression, and better use the workforce. This should be undertaken in consultation with clinical bodies.	●		
Action 104 Governments should encourage public and private partnerships that educate and train the health and care workforce by enabling them to work across settings, particularly in regional areas. This includes ensuring appropriate funding for private providers, given their capacity and expertise to offer training opportunities.	●		

Actions	By 2028 within 3 years	By 2030 within 5 years	By 2035 within 10 years
Action 105 Governments may also wish to consider other private sector workforce incentives to support workforce training, such as tax offsets for hosting clinical placements and for enrolling staff in university programs to upskill.		●	
Action 106 Australia needs to reduce its reliance on overseas-trained health and care workers and build its domestic pipeline, with exceptions for short-term needs.	●		
Action 107 National Cabinet should continue to implement the recommendations of the *Independent Review of Australia's Regulatory Settings Relating to Overseas Health Practitioners* to streamline access to professionals with in-demand skills.	●		
Action 108 Greater coordination is needed between the Department of Health, Disability and Ageing, the Department of Home Affairs, the Australian Health Practitioner Regulation Authority and Services Australia to ensure applications are processed efficiently and to improve access to Objective Structural Clinical Examinations.		●	
Action 109 Governments and providers should consider providing supports and wrap-around services for internationally trained workers, including adequate clinical support and appropriate cultural safety training. This may include targeted education to help understand how care is funded and delivered in Australia.		●	
Action 110 The Australian Government should consider enhancing education and training programs for international workers that provides both employment opportunities in Australia while delivering care. These workers could return fully equipped to deliver care to their home country's population.		●	
Action 111 The Australian Government respond to the House of Representatives Standing Committee on Social Policy and Legal Affairs *Inquiry into the Recognition of Unpaid Carers*.	●		

Actions	By 2028 within 3 years	By 2030 within 5 years	By 2035 within 10 years
Action 112 The Australian Government should consider a non-refundable progressive Carers' Income Tax Offset for unpaid carers, paid upon their return to the workforce. This would be for carers supporting family members who are aged, have disabilities, or are chronically ill.		●	
Action 113 Governments should ensure private-sector representation on government advisory bodies and partnerships for a holistic approach to service delivery. This should preference companies which deliver services. Representation may not apply to all advisory bodies or partnerships.	●		
Action 114 Governments need to recognise the role of the private sector and improve understanding of how to valuably increase engagement across sector participants.			●
Action 115 The Australian Government should recommit to addressing choice, competition and contestability in human services as part of the *Revitalising National Competition Policy* to ensure the effective service delivery across the public and private sectors while meeting the needs of an ageing population.	●		
Action 116 Governments should enable the private sector (including charitable entities, co-ops, mutuals and typical for-profit entities) to tender for the delivery of health and care services and broaden opportunities for private sector competition. Appropriate guardrails and governance frameworks can be implemented to address concerns regarding potential conflicts of interest.	●		
Action 117 Governments should consider the efficiencies of the tax arrangements (such as FBT exemptions) that place private health and care providers at various competitive disadvantages relative to the full range of public providers and among themselves. Any such change would need to form part of a holistic review of the tax system to lift business investment and productivity.		●	

Actions	By 2028 within 3 years	By 2030 within 5 years	By 2035 within 10 years
Action 118 The Australian Government must recognise state-based taxes and levies which impact the delivery of health and care services. These arrangements should be addressed through the ongoing National Health Reform Agreement negotiations.	●		
Action 119 The Australian Government should clearly articulate and define the elements of the economy – specifically health, disability and ageing, and formally recognise them as the Health and Care Economy.	●		
Action 120 The Australian Government should develop a National Health and Care Economy Strategy that provides a vision for all stakeholders: consumers, government, business, and providers.	●		
Action 121 The Australian Government should consider developing and including key performance indicators to drive greater accountability, ensuring effective reform is undertaken, improve consumer outcomes, and hold key decision-makers accountable.		●	
Action 122 The Australian Government should amend existing Ministerial portfolio arrangements to reflect the broader health and care economy and address its key challenges it faces, including workforce, prevention and digital health.	●		
Action 123 The Australian Government should create the Department of Health and Care Economy. The Department's organisational structure should also reflect the economy to enhance coordination and drive policy reform. State and territory governments should also consider adopting a similar approach.	●		
Action 124 Governments in partnership with the private sector and appropriate clinical bodies, should consider establishing the Australian Health and Care Commission, which would amalgamate the Australian Commission on Safety and Quality in Health Care, the Aged Care Quality and Safety Commission and the NDIS Quality and Safeguards Commission.			●

Actions	By 2028 within 3 years	By 2030 within 5 years	By 2035 within 10 years
Action 125 Governments in partnership with the private sector and appropriate clinical bodies should develop a set of National Health and Care Standards that consolidate the existing National Safety and Quality Health Services Standards (NSQHS), Aged Care Quality Standards, and the NDIS Practice Standards.			●
Action 126 National Cabinet should establish a specific taskforce or use the Ministerial Council on Health to identify and remove duplication, inefficiencies and overlap in health and care service delivery between federal, state and territory governments. A 12-month plan should be made publicly available, and the private sector should be consulted on this work.	●		
Action 127 National Cabinet should address the recommendations of the *Mid-term Review of the National Health Reform Agreement* and ensure they are reflected in the new agreement, as well as in ongoing aged care reforms, and NDIS reforms. This new agreement should be named the National Health and Care Economy Agreement.	●		
Action 128 National Cabinet should amalgamate other existing agreements as schedules to the National Health and Care Economy Agreement, such as mental health and First Nations.		●	
Action 129 National Cabinet should empower the proposed Australian Health and Care Commission or the Australian Health and Care Planning and Delivery Agency with the accountability and responsibility to implement any initiatives in the National Health and Care Economy Agreement.			●
Action 130 Governments, in liaison with the private sector and clinical bodies, should seek to harmonise legislation and regulation in areas such as drugs and mental health. This will reduce administrative and regulatory burden on providers and workers, and drive productivity.		●	
Action 131 All governments should genuinely commit to consulting with health and care providers to allow adequate time for regulatory changes to be implemented.	●		

Actions	By 2028 within 3 years	By 2030 within 5 years	By 2035 within 10 years
Action 132 National Cabinet should identify a national body to oversee the development and implementation of national clinical guidelines and determine how guidelines can be more broadly shared or adopted. National Cabinet may wish to consider overseas models.		●	
Action 133 National Cabinet, in partnership with the private sector, industry and clinical bodies, should consider developing national clinical collaboratives (such as the Paediatric Improvement Collaborative). This should involve the proposed Australian Health and Care Commission.			●
Action 134 The Australian Government should provide dedicated funding to enhance the adoption of the *Australian Atlas of Healthcare Variation Series*. This will support raising awareness of, and access to services that produce better outcomes. This work should involve the proposed Australian Health and Care Economy Commission.	●		
Action 135 All governments should amend existing government internal processes, including budget and new policy proposal processes, to ensure consideration of the longer-term impacts of health and care investments. This includes implementing more sustainable initiatives like preventative health programs.	●		
Action 136 All governments should receive informed evidence across departments on the potential impacts of new policies or initiatives on the population and the broader system. This advice should be made public, once a new policy is announced.		●	
Action 137 The Parliamentary Budget Office should amend the costings process to include broader economic effects for health and care proposals. This will ensure the longer-term benefits for initiatives such as preventative and digital are considered and incorporated.		●	
Action 138 The Australian Government should further leverage the National Health Data Hub to enable the better use of data being collected and used to support the evaluation of initiatives.	●		

Actions	By 2028 within 3 years	By 2030 within 5 years	By 2035 within 10 years
Action 139 The Department of Health, Disability and Ageing should effectively implement the *Evaluation Strategy 2023-26* in partnership with the Australian Centre for Evaluation to ensure significant policies and programs effectively address the needs of Australians, analysing value for money, consumer benefits, and unintended consequences. The rolling schedule should be made public.			
Action 140 The *Evaluation Strategy 2023-26* must include evaluations every three to five years for ongoing policies and programs to ensure they remain effective and deliver their intended outcomes. This recognises the evolving landscape, including changing models of care due to innovations and new technology.			

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