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Policy alignment for place-based solutions for better health outcomes in rural and remote communities

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Executive Summary

Rural and remote communities in Australia face persistent and well-documented barriers to accessing timely, person-centred care. These challenges are driven not only by geography and workforce shortages but also by the misalignment of policy, program, and funding structures that have evolved over time without coherent integration. Despite repeated calls for reform, siloed service delivery models, excessive administrative burden, and inconsistent funding mechanisms continue to hamper health outcomes.

Enabling place-based solutions in rural and remote Australia requires more than local action and community empowerment. It requires alignment, integration and enablement in government policies and programs to effectively and efficiently deliver those community-led, place-based solutions.

This policy brief, informed by AHHA Ltd member and stakeholder input and a cross-sector roundtable, highlights the need for national leadership to shift from fragmented, input-focused systems to coordinated, outcome-driven approaches. It presents four key areas for reform:

Informing local investment and integration

Disparate funding streams and limited visibility of investment at the local level prevent communities from co-designing integrated service systems. A shared commissioning and evaluation framework, aligned with Australia's *Measuring What Matters* Wellbeing Framework and the Health System Performance Assessment Framework, would enable more transparent and effective decision-making.

Prioritising care over administration

Health services in remote areas often manage dozens of funding sources, each with separate reporting and accreditation requirements. This diverts time and resources from care, both within services and in maintaining relationships between services and governments to build integrated service models. Rationalising compliance and enabling pooled funding through a single commissioning approach would reduce duplication and improve service efficiency.

Enabling a flexible, sustainable workforce

Misaligned pricing models and workforce policies across health, aged care, and disability sectors disadvantage integrated, place-based care. Resourcing and recognising local employer collaboratives to support coordinated workforce development pathways and flexible and integrated models essential to long-term sustainability.

Achieving aligned purpose across systems

Intergovernmental and cross-sector collaboration remains inconsistent, undermining local service design. Frameworks that focus on health and wellbeing outcomes, like those being adopted in Western Queensland, offer a model for aligning national initiatives with local needs.

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Introduction

Australia's complex and multi-dimensional health service system presents many barriers to delivering integrated, person-centred care, a major aspiration of evidence-based service delivery. These challenges are exacerbated in regional, rural and remote settings.

The broader ecosystem of primary care (primary and community care, disability, aged-care and wellbeing focused services) is also dynamic, with evolving pressures and delineations of responsibilities across jurisdictions. Social and economic policy settings, often excluded from traditional definitions of the health system and its infrastructure, significantly influence health outcomes and service demand. The complexity and disconnection across these policy domains can entrench siloed delivery models, especially where service markets are thin or non-existent.

Rural and remote communities also face well documented barriers to accessing timely health care, particularly for primary and preventive care. This results in health needs that are disproportionately higher than in more populated areas, reflected as elevated rates of disease and preventable hospitalisations. This is a consequence of inflexible and inconsistent policy and program structures that have developed iteratively over time and are often poorly aligned with the realities of delivering broad, cross-system services in low population settings. Ultimately, this has created compliance-driven approaches that are inefficient and fail to address local need.

Decades of government reviews have consistently identified common priorities for reform to improve outcomes for rural and remote communities. These include:

- Appropriateness of policy/program/services design and implementation to meet rural and remote needs
- An outcomes-based approach that delivers real impact for residents in rural and remote communities
- Coordination and integration of policy and programs that prioritises efficient, locally co-designed services that engage and support person-centred care
- Empowered health literate residents maintaining wellbeing
- Access and outcomes for identified population groups, notably First Nations Australians, older Australians and those people with disabilities.

Governments have recognised that these imperatives can be achieved more effectively and efficiently through mechanisms developed around local circumstances, potential capacity and opportunities.

Most recently, the Australian Government reinforced its commitment to person-centred and place-based reform through the announcement of the Partnerships for Local Action and Community Empowerment (PLACE) initiative (PLACE, n.d.). PLACE is intended to support communities to identify tailored, place-based solutions to address their needs and aspirations in areas they identify such as the early years, health, education, employment, youth justice and net zero.

However, enabling place-based solutions in rural and remote Australia requires more than local action and community empowerment. It requires alignment in policies and programs to effectively and efficiently deliver those community-led, place-based solutions.

For health, this is required across diverse national and state/territory policy areas, central and line agencies, and across program areas. Alignment is more likely to be achieved where policy and program design, and performance assessment, prioritises outcomes and impact over standardisation of inputs and processes.

This Policy Brief draws together a series of examples that illustrate how misalignment of existing policy and program settings impacts the effectiveness and efficiency of service delivery and the experience of rural and remote communities and their access to health and care services.

Informing local investment and integration

Context

It is broadly recognised that the Medicare fee-for-service funding model does not encourage integrated care, continuity or preventative health in primary care (Chen, et al. 2024). As such, and over time, alternative funding arrangements have been implemented by the Australian Government to address different areas of need, including (but not limited to):

- salaried arrangements for those employed in underserviced populations (e.g. remote government-funded clinics, Aboriginal Community Controlled Health Organisations)
- incentive payments (e.g. for participating in quality improvement activities, workforce engagement and support, bulk-billing and registering patients with a practice)
- grant and pilot/trial funding
- commissioning of services through Primary Health Networks and/or state/territory governments
- funding provided for health care through the National Disability Insurance Scheme (NDIS) and aged care services
- agreements for specific services, (e.g., pharmacist services through the Community Pharmacy Agreement, Royal Flying Doctors Service, workforce agencies)
- application of rural loadings to fees.

Funding is also provided by the state/territory governments, through (Commonwealth subsidised) private health insurance and through philanthropic contributions.

Different evaluation strategies and frameworks are applied to different funding arrangements, and there are no explicit requirements for integration of funding streams.

Challenge in the rural and remote context

The diverse funding arrangements available to rural and remote communities limits their ability to contribute to informed decision-making about health service design in their region, due to a lack of visibility of the:

- volume of funds being invested and available for the provision of health, aged and disability care services
- funds for developing and sustaining workforce capability
- time periods for which that funding will be sustained
- purpose and performance expectations associated with that funding.

This is evident in the way effective integration and coordination of services at the community level often depend on individuals prioritising its importance, rather than being driven by formal governance structures and requirements.

Without a clear view of resources and a requirement for integrated implementation, the co-design of local systems of care is undermined and people in rural and remote communities bear the burden. See Case 1.

Case 1: Increased patient burden when services do not integrate locally

Summary of misaligned policy

In many circumstances, travel is a major barrier to accessing health care in rural and remote communities across Australia.

In this setting, mobile health services are used to provide equitable access to a range of specialities and clinical services using custom-designed mobile units funded through multiple sources, government, philanthropic and charitable arrangements, to support access to care without requiring patients to travel.

However, there is no explicit requirement (e.g. in funding or governance arrangements) for such mobile units to integrate with the existing local service system in communities.

Impact on rural and remote communities

In the immediate term, access to specialists and services through mobile units has been found to improve the experience for individuals accessing care. However, without integrating these units into the local service system, it has also been found to lead to an increased burden on both individuals and service providers.

For example, if a referral for another service is deemed necessary, a lack of understanding/awareness about the availability of services provided routinely in the region, may result in the mobile unit referring the person to a metropolitan location, requiring travel for further diagnostics or treatment, even when a local or regularly visiting service could address the need without requiring travel.

Opportunity

To address issues of investment and integration in the rural and remote context, a shared commissioning and evaluation framework that supports cross sector design and decision making around federal funding arrangements from a place-based perspective could be developed.

This would build on the work of the Australian Centre for Evaluation within the Australian Government Treasury and its agenda to improve the volume, quality and use of evaluation evidence to support better policies and programs.

A broad range of motivations for evaluation of activities across entities, as well as multiple uses of evaluation evidence, have been identified in the Centre's inaugural report on the *State of Evaluation in the Australian Government 2025*[ii].

The development of a shared evaluation framework would also be consistent with the new Health System Performance Assessment (SPA) Framework, currently being developed through collaboration between the Australian Institute for Health and Welfare (AIHW) and the Australian Commission on Safety and Quality in Health Care (ACSQHC).

The draft SPA Framework recognises that 'the world today is awash with data and the sheer volume of data can be a barrier to its effective use' with a direction being set that draws attention to:

- The use of a 'learning health system approach' to connect data to policy action
- Its primary purpose in supporting 'shared stewardship, mutual understandings, continuous improvement and innovation'
- The introduction of 'meaningful' outcome indicators, that is, that information is relevant to and actionable by health leaders.

To establish a critical baseline, the Australian Government should transparently report the volume of funding at a community level, detailing recipients, purposes and performance expectations. This will support the co-design of local systems of care and ensure accountability to rural and remote communities.

Australian Government funding agreements must also require the inclusion of the ongoing and active participation of funding recipients in the co-design and implementation of systems of primary care.

This includes collecting and sharing health outcomes data, as relevant for assessing and monitoring improvements against community priorities at the individual level (to support continuity in their care) and to understand population need.

Prioritising care over unnecessary administration

Context

With the size of a population influencing the capacity for a community to generate activity to sustain viable health and care services, the service profile of health service organisations in rural and remote communities may require them to provide services spanning aged care, primary and community care, hospital, disability and mental health services.

Such a service profile is accompanied by multiple funding sources, with service providers being asked to comply with varying reporting and administrative requirements from each source. For example, it is not uncommon for a single service to draw from upwards of 50 different funding arrangements in order to deliver care that meets the needs of the population.

Challenge in the rural and remote context

Funding intent for relational care, but driving transactional care

The large number of funding arrangements in place to support the breadth of needs in communities with small populations, restricts relational and needs-based models of care.

The intent for blending different payment systems includes to incentivise less transactional approaches to care. However, the administration of different payment systems through multiple entities can itself prohibit service providers from implementing relational models of care as service providers are restricted by inconsistent compliance and reporting requirements of each system.

Further, while place-based commissioning through relational models is intended to respond to local areas of need, implementation in regional and remote populations is still challenging because of inflexible funding, high transaction costs, overcompliance, and poor relationships (Boer, et al., 2025).

As such, the funding arrangements designed to address areas of need have not only added an excessive administrative burden to health services, but restrictions on the use of funding results in gaps, duplication and fragmentation in health service provision.

Reporting burden

Each funding source has independently determined reporting requirements. These may stem from directives or guidance from the Australian Government Department of Finance for achieving value in the management of public resources (Australian Government Department of Finance, n.d.), through to those made within individual government departments for individual programs. Sometimes the reporting requirements may not be explicit directives but have evolved to become standard practice, often as a result of the culture within the specific department or program area. Such arrangements appear to persist without independent or broader review to assess their alignment with policy objectives or contemporary need.

Accreditation burden

Health service organisations will require accreditation against standards related to the service profile of the organisation. When that

service profile spans multiple sectors and services, accreditation against multiple standards will be required. This is the case for many rural and remote services that provide more fully integrated services but at smaller scale – where primary health, aged care, disability, hospital and mental health services all have separate standards and accreditation processes.

For example, in the provision of mental health services, in addition to accreditation against the National Standards, there are also separate processes for accreditation of digital mental health services and against the headspace Model Integrity Framework.

The burden of accreditation in this context can be disproportionate given the resources required to carry out separate assessments against each set of standards. There may also be challenges adjusting to differences in their orientation (some focused on compliance, while others to learning cultures and continuous improvement). Frequently the same, or similar, expectations of care (and professional service obligations) should apply to an occurrence of care, regardless of the funding source which provides or subsidises the service.

Further, inconsistent and input-focused reporting obligations can result in restrictive models of care and a high administrative burden for service providers.

Opportunities

Aligned compliance requirements

For rural and remote communities, there is opportunity to drive relational care through shifting away from inconsistent reporting and associated compliance requirements across and within health, aged and disability sectors.

This can be achieved through a whole-of-government review of accreditation and reporting obligations (and the basis for those obligations) applied by Australian Government departments to health services that deliver care in rural and remote communities. Prioritising alignment will reduce excessive administrative burden on service providers that are reliant on multiple funding sources.

Rationalisation and coherency of standards for providers in rural and remote communities is critical to reduce duplication, inconsistencies in expectations and the administrative burden. This will allow the available workforce to direct their time more appropriately to the provision of care, as well as have flexibility in introducing more outcome-focused models of care.

Pooled funding with relational commissioning

For remote communities, to reduce the administrative burden, there is opportunity for funding to be pooled at a community level and allocated through a single relational commissioning approach.

As communities become less remote (according to an appropriate categorisation system for rurality), the shift to blended and activity-based models of funding could then be enabled.

Enabling a flexible workforce to meets community needs

Context

A strong and effective health workforce is essential to a functioning health system. However, workforce challenges continue to be identified as one of the most critical issues limiting universal access to health care. The challenges are diverse, and not unique to Australia (WHO, 2016). Workforce shortages, skill-mix imbalances, maldistribution, barriers to inter-professional collaboration, inefficient use of resources, poor working conditions, a skewed gender distribution, limited availability of health workforce data, persist, often within an ageing workforce.

However, policy levers are too often applied inconsistently across different sectors, our federated system and in relation to the global workforce market, and this is no different in rural and remote Australia.

Challenges in the rural and remote context

Pricing and payment models misaligned with population need

Pricing and payment models are inconsistent across health, aged and disability sectors. Workforce development is therefore also influenced in silos by sector or profession, rather than to meet population needs. This has a disproportionately higher impact on the ability to sustain services in rural and remote communities where there are thin or no markets.

In addition, providers are not incentivised to commit to sustained access to services in the community. When funding and associated policy levers favour efficiency of service provision through competitive and market-based approaches, the viability of services committed to sustained services over time can be threatened. See Cases 2 and 3.

Case 2: Pricing for allied health through different schemes

Likely the biggest disruptor to the supply of allied health services in rural communities is the pricing arrangements for the National Disability Insurance Scheme (NDIS), relative to the Medicare Benefits Schedule (MBS) (Figure 1).

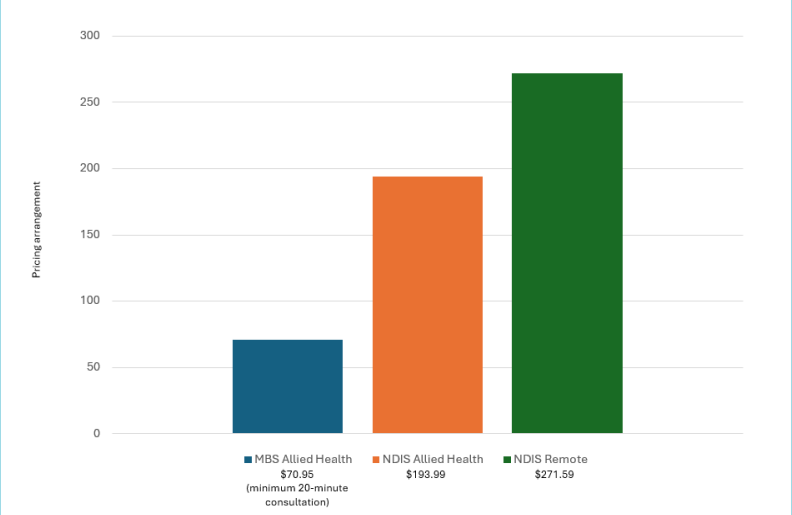


Figure 1: Pricing arrangements for allied health services

Summary of misaligned policy

NDIS pricing arrangements (NDIA, 2024) state that items can be used to claim for direct service provision, non face-to-face support provision, provider travel and short notice cancellation. Providers can also claim for the non-labour costs associated with travel (road tolls, parking fees, vehicle running costs). For group treatment, the pricing applies proportionately to the number of people involved.

This contrasts with MBS items, where the provider must attend the appointment in person, treating the patient face-to-face and not through group treatment (Services Australia, 2024).

Impact in rural and remote communities

These pricing arrangements result in services claimed through the MBS largely only being viable for providers living locally (due to travel not being supported) and hinders the adoption of more innovative models of care (e.g. asynchronous and group care). Also see Case 3.

Case 3: Workforce development disconnected from sustaining services in the long term

Summary of misaligned policy

While funding in primary health care comprises a complex series of payment opportunities available against a background of Medicare fee-for-service, the NDIS applies a pricing arrangement that is stated to estimate the fully loaded cost of a billable hour considering such aspects as base pay, shift loadings, leave entitlements, salary on costs, employee allowances, operational overheads (including supervision costs, utilisation costs, workers compensation costs), corporate overheads and margin.

In rural and remote areas, higher price limits are applied than in metropolitan areas to reflect the increased operational costs in delivering services in these regions. However, the pricing in place does not distinguish between small, sole providers and larger providers.

As such, service provision under the NDIS is comparatively more attractive for small, sole providers. Without overheads, and with the ability to select less complex clients and/or avoid outreach, business profitability is greater.

Impact on rural and remote communities

For larger service providers that are embedded in communities and committed to the longer-term sustainability of service provision, viability is challenged by the overheads, compliance costs and investments in workforce development for operating at scale and sustaining activity over time.

Input-focused workforce obligations in funding contracts

Compliance requirements specified in contracts for different funding arrangements across health, aged and disability sectors can introduce input-focused workforce obligations that restrict models of care in a region. For example, a mental health service contract may specify a full-time equivalent requirement for clinical psychologists. Where there are not clinical psychologists in a region, the funds cannot be directed to alternative innovative models of care (e.g., virtual, peer) that can support improved mental health outcomes.

Lack of recognition and alignment of enabling/supporting roles

In rural and remote areas, poor recognition of the enabling/support workforce developed through the vocational education and training (VET) sector within health service systems undermines the capacity for rural and remote communities to design integrated models of care that achieve person-centred, place-based care.

In communities where single sector service models are often not viable, the siloing of pathways from study into employment across the health, aged care and disability sectors has a significant impact. Without common, entry level qualifications, the ability to attract candidates into the 'care economy' is impacted by limited visibility of the diversity and flexibility of careers opportunities. Further, it impacts the ability to identify and build local capacities.

Inconsistent recognition of roles is seen, for example, with community connector roles (see Case 4). Their impact on supporting

navigation and continuity of care is dependent on them operating within safe delegated and connected models of care, but which requires consistent recognition of their role in policy and funding across the health, aged care and disability sectors.

Case 4. Connecting with community crucial to access

Misalignment of policy

Community connectors have been defined as 'socially engaged citizens who facilitate flows of information, relationships and access to resources between different and disconnected parts of the community' (Wallace, et al. 2020). In Australia, a range of community connector programs operate, e.g. to support delivery of the NDIS (NDIS, 2024) and through state government public health programs to reach specific populations (NSW Health, 2025).

As community connectors operate at the boundaries between community and health services, their impact is dependent on them operating within safe, delegated and connected models of care that support services to integrate and facilitate community access to care.

In rural and remote communities, this requires a shared understanding of their role and agreed integration with services across the health, aged care and disability sectors.

Impact on rural and remote communities

Despite rural and remote communities experiencing a lack of access to health services, there are also many examples of health services made available in those communities that are not accessed. These may be identified in varying ways, such as planned appointments where a person 'Did Not Attend (DNA)' or a visiting service that reports low engagement.

It is increasingly being recognised that the responsibility lies with the service system to consider the factors which lead to services not being accessed, rather than blaming the individual. However siloed responsibilities and funding arrangements result in connector roles not being embedded in system structures.

Opportunities

In rural and remote areas, there is an opportunity for the Australian Government to drive alignment of funding models for a more flexible workforce that operates across health, aged care and disability sectors, such that meeting population health needs and sustaining services and the workforce at a local level are incentivised.

Cost and price distinctions need to be considered, in a framework that attempts to identify cost-effective delivery in terms of access and outcomes for local populations.

Policy levers and associated funding streams (both at a national and state/territory level) would need to be flexibly applied at the local level, responsive to the workforce and health needs of the community.

Workforce planning processes and the vocational education and training (VET) systems need to be inherently connected and

responsive to the needs of the service systems in rural and remote Australia.

Local employer collaboratives in rural and remote communities should be resourced and recognised for informing national policy and investment that is responsive to local needs.

Achieving aligned purpose

Context

The Commonwealth and States and Territories have long shared many roles in policy, funding and regulation of the health system, with service delivery largely undertaken by the state and territory governments and the non-government sector.

Over time, intergovernmental agreements relating to health have evolved the roles and responsibilities of different tiers of government; from pre-Medicare Agreements, to Medicare Agreements (1984), Australian Health Care Agreements (1998), the Intergovernmental Agreement on Federal Financial Relations (2008) and the associated National Healthcare Agreement and Partnership Agreement, the National Health and Hospitals Network Agreement (2010) and the National Health Reform Agreements (2011). The challenges faced in rural communities feature in the narrative (The Senate Select Committee on Health, 2016).

The current National Health Reform Agreement (2020) defines its purpose as 'the shared intention of the Commonwealth, State and Territory governments (the States) to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system' (Australian Governments, 2020). Across Australia, there are a wide range of joint governance arrangements for collaboration between Local Health Districts (or equivalent) and Primary Health Networks, some having been established for decades. Different or more flexible approaches in regional, rural and remote communities are recognised in various clauses.

Challenge in the rural and remote context

In the rural and remote context, for decades it has been reported (Wakerman, et al., 2006) that rural health policies should be driven by the need to reduce health inequalities between metropolitan and rural Australia, and with recognition (Standing Council of Health, 2020) of the unique characteristics and challenges in planning, design, funding and delivery of quality, contemporary health care.

Further, the inextricable link between health services and the wellbeing of their communities is often not explicitly recognised in decision-making. The impact of health services is more than just the provision of health care. They also have influence, e.g., on employment, investment and purchasing decisions within the local community. The decisions that are made about the way health care is provided thereby impacts the safety, vibrancy, and stability of those communities.

Despite commitment expressed for regional joint governance arrangements, the systems of primary and preventive care in rural and remote communities can be undermined by national (cross-sector) policy and programs designed for metropolitan markets.

With no framework being used to operationalise bringing national policy makers together with local stakeholders around a shared purpose of improving health and wellbeing at a local community or population level:

- The understanding of the opportunities and impact of decisions made about place-based health service design is limited;
- Structures that facilitate use of resources to meet common priorities and goals are not recognised; and
- The extent to which initiatives are demonstrably contributing individually and collectively to the wellbeing of communities lacks transparency.

Opportunity

To align purpose in the rural and remote context, there is an opportunity to bring together global evidence and experience for value-based health care (VBHC)[1] in driving improved health outcomes, with the Australian Government Treasury's national wellbeing framework (Australian Government Treasury, 2023) focused on building a healthy, secure, sustainable, cohesive and prosperous Australia for everyone.

A shift to focus on the measurement of health outcomes of individuals occurs, supplemented by adoption of the federal government's Measuring What Matters wellbeing framework, would allow the Australian Government to gain a shared understanding of the impact of different models of service design on communities.

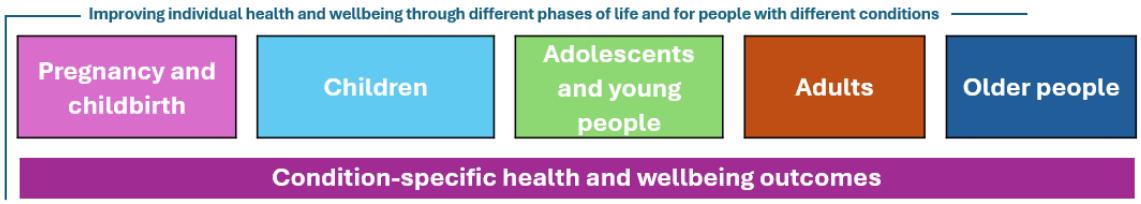
Western Queensland PHN has developed such a framework for health and wellbeing outcomes in the Western Queensland region and is now, under an alliance governance model, progressing iterative implementation with service providers through their commissioning for outcomes framework (see Case 5).

[1] Globally, health systems are shifting towards VBHC as a structured approach to bring all the various stakeholders across the system together to drive transformational reform that focuses on the collective goal of improving the outcomes that matter to people and communities. With origins in the United States, VBHC focuses on the systematic and coordinated measurement of health outcomes. Its adoption by health systems that prioritise universality has seen evidence and experience that resonates in the Australian context (e.g., the Welsh model), including in remote and rural Australia (Hoban, et al; 2024). Application of VBHC in Australian health services is emerging and demonstrating positive results in diverse contexts (AHHA; 2025).

Case 5. A framework for health and wellbeing outcomes in the Western Queensland region

Aspirations for the framework

- To support a complex and multi-player, multidimensional health service system to align for place-based service design.
- To achieve this through enabling the systematic and coordinated measurement of health and wellbeing outcomes across the region.
- Ultimately to achieve demonstrable improvements in the health and wellbeing outcomes that matter to people and communities.



Outcome statements	Outcome statements
Healthy	Communities in which people feel well and are in good physical and mental health, can access services when they need, and have the appropriate health education and support they require to take action to improve their health.
Secure	Communities where people live contentedly, feel safe, have financial security and access to housing.
Sustainable	Communities that sustainably uses natural, financial and human resources, protects and improve the environment and build resilience.
Cohesive	Communities that support respectful connections with family, friends, country and place, value diversity, and promote belonging, wellbeing and culture.
Prosperous	Communities that have a dynamic, resilient and sustainable economies, with investment in people's skills and education, and providing purposeful occupation and secure income.

The framework

- Its development is grounded in international and national evidence and experience in VBHC, with value recognised 'as a relationship between resources, outcomes and context' (Hurst et al., 2019)
- It is also framed around The Australian Government Treasury's national wellbeing framework, Measuring What Matters, with initial implementation achieving a shared understanding of health literacy, relational and informational continuity, navigation, cultural safety and trust in health care to support shared decision-making about service design and commissioning.

Implementation

- Requires the system to commit to an iterative approach towards these aspirations, adopting outcome measures within a common framework and collaborating to transparently measure, monitor and understand the impact of initiatives and services.
- The framework centres decision-making around health and wellbeing through different phases of life and for people with different conditions, but also recognises that in designing health services, particularly in rural and remote communities, these must be considered in the context of the factors that drive a healthy, secure, sustainable, cohesive and prosperous community.
- Implementation according to the commissioning for outcomes framework, iteratively introduced for condition-specific outcomes and life phases.

Conclusion

This Policy Brief highlights that enabling place-based solutions in rural and remote Australia requires more than local action and community engagement. The effective and efficient delivery of those community-led, place-based solutions requires federal policies and programs to:

1. Align

This requires whole-of-government commitment to policy aligning for services on the ground,

- removing administrative burden and enabling flexibility of resources to be directed to optimise provision of care; and
- requiring health services to engage in collective improvement of health and wellbeing for communities rather than competing for resources.

This requires broad-based (cross portfolio) evaluation strategies to be adopted, including demographic and economic analyses at the community/population level to better identify the target policies for greater impact and return on investment.

This requires Governments to consult on and evaluate policies and programs holistically in the rural and remote context around health and wellbeing outcomes that matter to the community. Rurality classification systems must be used consistently to understand the extent to which policies and programs are improving health and wellbeing outcomes in different geographical contexts.

2. Integrate

This requires health services delivering in the community, no matter how they are governed, managed or funded, being required to understand and integrate for coherent care pathways for people and communities.

This requires service delivery and workforce development being seen as inherently connected and mutually reinforcing, not as distinct objectives developed in parallel.

This requires a single relational approach to commissioning at a regional level ensuring integration and allocation of funding directed to improving health and wellbeing outcomes.

3. Empower

This requires the conversation with communities shifting from a focus on inputs (a building or a profession) to the outputs they want (time to diagnosis, support for self-management) and ultimately outcomes (e.g. reduced rates of preventable disease or hospitalisation), enabling innovation in delivery models.

This requires greater transparency for communities on the resources available in their communities and how they are used to achieve these outcomes.

This requires trust being built with health services that are operating within communities, recognising the delicate ecosystem within which they operate. This requires recognition of the investment required for relationships that underpin long-term sustainability of services, over short-term savings from transactional approaches. This requires prioritisation of governance and delivery arrangements that bias collaboration over narrowly focused administration and accountability.

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AHHA acknowledge the Aboriginal and Torres Strait Islander peoples as Australia's First Nation Peoples and the Traditional Custodians of this land. We respect their continued connection to land and sea, country, kin, and community. AHHA also pays our respect to their Elders past, present, and emerging as the custodians of knowledge

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