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# Perspectives Brief

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# The role of Health, Research and Education Precincts in establishing local learning health systems and achieving value-based healthcare

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# Background

Health Research and Education Precincts (HREPs) play a critical role in advancing value-based healthcare (VBHC) by bringing together researchers, clinicians, educators, and policymakers to enable evidence-informed, outcome-driven care. Despite growing evidence of the tangible benefits that HREPs bring to health systems, without ensuring their long-term sustainability, Australia risks missing opportunities to scale high-impact, value-based care models.

## Value Based Health Care (VBHC)

The Australian healthcare system is undergoing significant transformation to address evolving and increasing demands. Like many developed healthcare systems, it faces challenges in delivering high-quality, sustainable care in this dynamic environment (AIHW 2024; OECD 2025). Within this domain, traditional output-based measures of healthcare performance are insufficient to support the sector's future needs (Wasylak et al. 2022).

Value-based healthcare (VBHC) has emerged as a global response to these challenges. Aiming to achieve the best possible outcomes for people receiving care at the lowest cost; VBHC will be pivotal in meeting the healthcare needs of individuals and healthcare systems (Lewis 2022).

VBHC shifts the focus from outputs to multidimensional value, considering the patient experience, population health, provider experience, healthcare costs and equity - aligning with the healthcare quintuple aim (Nundy et al. 2022), which emphasises the importance of fostering trust, communication and engagement between patients and healthcare providers.

VBHC underpins sustainable delivery of healthcare, yet healthcare systems around the world have struggled to systematically embed it in practice. In part, this is due to the significant structural, cultural, and financial changes required across healthcare systems for its successful delivery.

As a mechanism to deliver VBHC, Learning Health System (LHS) as a concept have been embraced by researchers, funders, managers, and clinicians as a means to embed the capture, analysis, and translation of new knowledge into the practice of healthcare delivery (Zurynski et al. 2020),

## Learning Health Systems

LHS are dynamic healthcare ecosystems that continuously and systematically integrate data, research, and practice to improve patient care and health outcomes (Figure 1). LHS foster a culture of ongoing learning where every experience, decision, and outcome become part of a cycle of continuous improvement (Menear et al. 2019; Wasylak et al. 2022). Central to an LHS is bidirectional learning, where evidence informs practice and practice, in turn, informs evidence (Greene et al. 2012).

However, as a structural component of VBHC, transitioning to a LHS is a complex and challenging process requiring the development of new competencies, investing in infrastructure, and adopting innovative practices to fully realise its benefits.

To overcome these challenges, HREPs are now being proposed as a means of building on LHSs and systematically embedding the concept to advance the VBHC agenda.

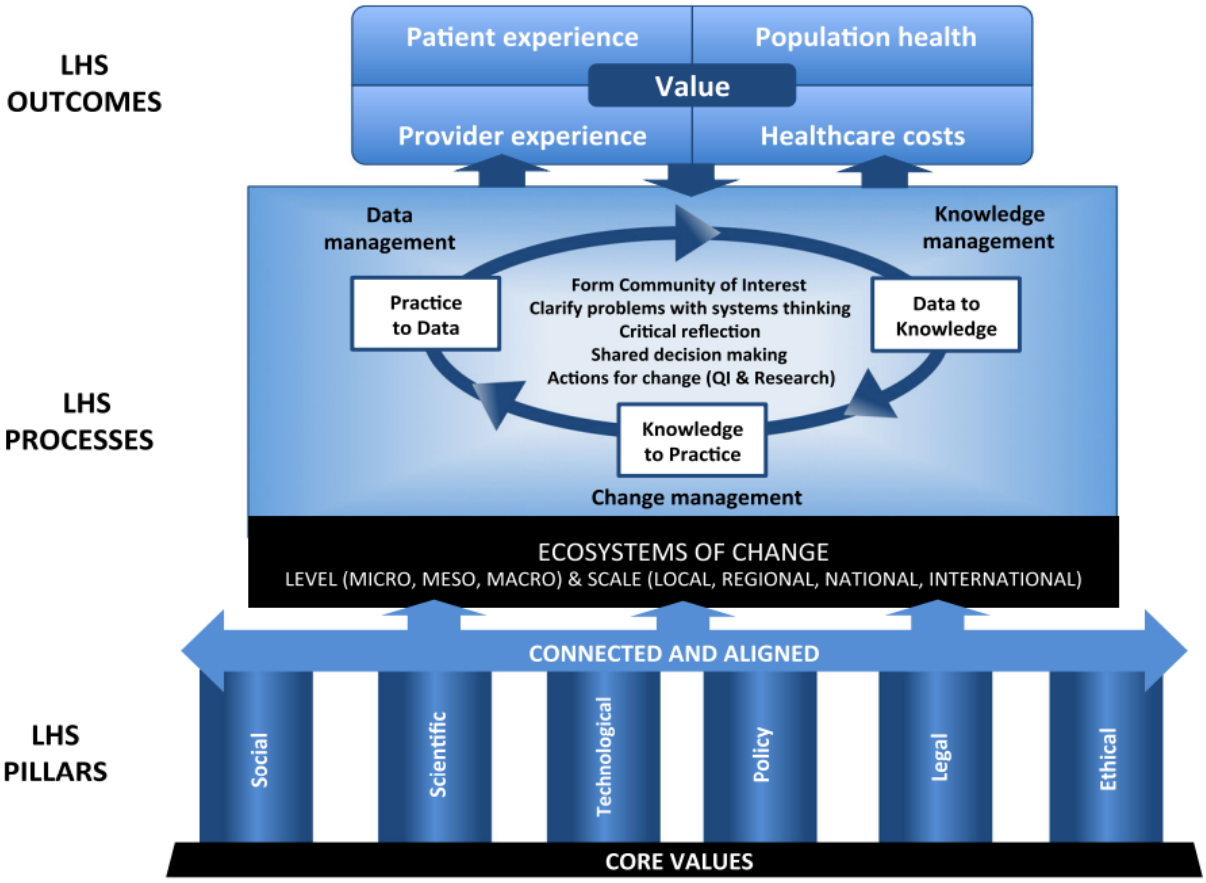


*Figure 1: Conceptual framework for value-creating learning health systems (Menear et al. 2019).*
*LHS Pillars: The foundational, enabling infrastructure and resources that create the conditions for continuous learning and improvement in health systems.*
*LHS Processes: The cyclical activities of collecting and analysing data, generating evidence, and translating knowledge into practice to drive change.*
*LHS Outcomes: The tangible results of an effective learning health system, aligned to the principles of value-based healthcare.*

## Health Research Education Precincts (HREPs)

HREPs are dedicated areas or hubs that integrate research, education, and clinical care to advance healthcare outcomes. Bringing together healthcare providers, universities, research institutes, and industry partners in a co-located ecosystem, HREPs ensures that healthcare innovations are rapidly adopted and implemented (Randwick Health & Innovation Precinct 2021).

Therefore, although LHS focus on integrating research into practice within existing healthcare systems, HREPs take a broader approach to innovation and collaboration, encompassing multiple LHS within their infrastructure and providing a more comprehensive and integrated environment for advancing VBHC (Table 1).

*Table 1: Role of Health, Research, Education Precincts (HREPs) in supporting Learning Health Systems (LHS) and value-based health care (VBHC)*

| | Role of HREP | Impact on LHS/VBHC |
|---|---|---|
| Integration of Research, Education, and Clinical Practice | Enabling Real-Time Learning: HREPs bring together researchers, clinicians, educators, and health services in one place. | Supports continuous learning cycles, accelerating the application of research into care. |
| | Embedding Evidence into Care: Co-located teams translate research into clinical practice. | Aligns with VBHC's focus on evidence-based, outcome-driven care. |
| Data and Digital Infrastructure | Centralised Data Systems: Accessible, shared, interoperable data platforms enable real-time monitoring of patient outcomes. | Essential for tracking and improving value-based care and learning health system goals. |
| | Analytics and Decision Support: On-site expertise in data science and informatics enhances decision-making. | Strengthens capacity for measuring outcomes and optimising care delivery. |
| Workforce Development and Cultural Shift | Training for Value and Learning: Embedding LHS and VBHC principles into education ensures future-ready clinicians | Ensures clinicians and are skilled in data-informed care, continuous improvement, and patient-centred approaches. |
| | Leadership and Change Management: HREPs cultivate leadership for system innovation. | Drives a cultural shift toward collaboration and value-driven care. |
| Cross sector collaboration | Multidisciplinary Teams: HREPs bridge academia, healthcare, and government to enhance collaboration. | Supports integrated learning and system-wide adoption of best practices, enhances efficiency and reduces duplication. |
| | Policy-Research-Practice Nexus: Acts as a testing ground for policy implementation and scaling reform. | Accelerates the translation of research into policy and system improvements. |

In Australia, several HREPs have already been established. These include, among others, the Melbourne Biomedical Precinct (Vic), the Westmead Health Precinct (NSW), the South Australian Health and Medical Research Institute (SA) and the Queensland Health and Knowledge Precinct (QLD). However, for HREPs to fully realise their potential, strategic support and prioritisation from national policies are essential.

# Benefits of HREPs

## Integration of research, education and clinical practice

Research is a foundational component of a high-performing health system, equally vital as clinical care and health workforce training (Brown et al, 2022), with evidence over recent years confirming that integrating research and education within health services not only builds a more capable health workforce, but also improves care quality, enhances patient outcomes (Brown et al. 2022; Archibald 2023; Gould et al. 2020).

HREPs operationalise this vision, providing the physical and cultural infrastructure needed to embed research and education into routine care, accelerating learning, fostering innovation, and enabling real-time impact.

HREPs move beyond the traditional *bench to bedside* approach to research translation. They drive, dynamic LHSs, ensuring research and innovation translate into real-world impact for patients and communities. As operational models of LHSs, HREPs, have the capacity to redesign and coordinate care, enable and support behaviour change, improve clinical decision-making through real-time tools, and strengthen patient-clinician relationships (McDonald et al. 2021; Teede et al. 2024).

In doing so, HREPs bridge the gap between discovery and delivery, enabling VBHC that improves outcomes, enhances experiences and reduces harm.

Environments with strong research and education integration, including HREPs have demonstrated; fewer hospital-acquired complications, better chronic disease management, higher adherence to clinical guidelines, and stronger performance against quality metrics (Bierbaun et al. 2025). This impact extends beyond the bedside.

When applied at scale or targeted to priority populations, integrated approaches to health, research and education have been shown to improve equity (Schoenthaler et al. 2023); helping ensure all Australians receive the care they need, regardless of who they are or where they live.

The benefits of integration extend well beyond clinical care. Embedding research and education across key systems functions, such as health informatics, implementation science, and health economics, enables more efficient, resilient and cost-effective services (Peters et al. 2023).

**Australian Institute of Health Innovation (AIHI): cornerstone of Macquarie University's precinct.**

The Australian Institute of Health Innovation (AIHI) at Macquarie University (NSW) is a research-intensive institute focused on multidisciplinary research in health systems, safety, resilience, information and implementation science. The Institute is comprised of four core research centres:

- Centre for Healthcare Resilience and Implementation Science (CHRIS)
- Centre for Health Informatics (CHI)
- Centre for Health Systems and Safety Research (CHSSR)

- Macquarie University Centre for the Health Economy (MUCHE)

Co-located with industry partners in Macquarie's innovation district, AIHI researchers work alongside clinicians and educators at associated hospitals and clinics, contributing to education, clinical trials, service improvement, and health innovation initiatives. AIHI also provides cross-disciplinary higher-degree research training that draw upon resources from both academic and clinical settings.

Critically, the Institute fosters collaboration across disciplines to drive evidence generation forward towards system implementation.

As the research and educational cornerstone, AIHI plays a pivotal role in bridging the academic, clinical, and innovation aspects of the HREP.

## Workforce development and cultural shift

Achieving meaningful healthcare transformation also depends on how we invest in and enable the health workforce.

Integrating education into real-world, research active clinical environments is a foundational requirement for a modern, adaptive health system. It strengthens interprofessional learning, sharpens clinical decision-making, and fosters systems thinking. When staff learn in the same environment in which they work, theory becomes practice and the gap between what we know and what we do begins to close (Pearce et al. 2022; Zieber & Wojtowicz 2020; Verhees et al. 2024).

While embedded learning models exist (Baxendale et al 2022; Verhees et al. 2024), they are too often siloed, time-limited, and lacking coordination. These issues can be addressed through the establishment of HREPs.

To embed a culture of continuous improvement, HREPs align research, education, and care through coordinated structures and shared purpose, making learning a core feature of daily healthcare delivery rather than a parallel activity (NSW Health, 2025).

For example, health organisations engaged in research demonstrate improved performance and patient outcomes (Boaz et al. 2024). While clinicians who engage in research are more likely to adopt innovation, lead quality improvement, and deliver better patient outcomes (Boaz et al. 2015; Boaz et al. 2024).

In addition, working at the intersection of healthcare, research, and education enables clinicians and managers to expand their expertise, enhance their capabilities, and contribute more effectively to system improvement (Chang et al. 2021). In this regard, HREPs foster career pathways and contribute to development opportunities for staff at all levels. This model can support staff operating in LHS, who need bespoke, cross-disciplinary capability, beyond what traditional education provides. This includes education and training in (Yano et al. 2021):

- leadership
- implementation science
- health economics
- digital and data literacy
- communication and systems thinking

Importantly, HREPs also support an often-overlooked group within the health system – non-clinical staff, health managers, system

leaders, analysts, and administrators who are central to the success of healthcare (Figueroa et al. 2019). By providing targeted education and opportunities to engage in health systems research, HREPs enable these professionals to grow, lead, and contribute strategically to health, research and education outcomes.

By aligning health, research and education under a shared vision, HREPs drive a transformative shift in workplace culture (NSW Health, 2025). They foster environments where staff are empowered to ask questions, challenge the status quo, and innovate with purpose.

In these environments, ideas flow freely, and innovation is not only encouraged but expected. The result is a more skilled, connected and future-ready workforce delivering, safer, more efficient and high-quality care (NSW Ministry of Health, 2020).

### Data and digital

Harnessing the combined power of data and digital innovation across healthcare, research, education and industry represents a major transformative opportunity within the HREP framework.

By bringing together the data assets and digital infrastructure across healthcare, research and education sectors, HREPs enable a level of insight and agility that few individual organisations could achieve alone. This convergence of data unlocks the ability to identify inefficiencies, test new care models, and drive high-value, cost-effective improvements across clinical and operational domains.

Embedding cross-sector centralised data systems, or at a minimum cross-sector data sharing, supports not just real-time decision-making and advanced analytics but also accelerates translational research and fosters integrated care (Alderwick et al. 2021).

Shared data enables, facilitates, and promotes (Whicher et al. 2021):

- real-time clinical decision-making
- predictive analytics
- connected care pathways
- state-of-the-art translational research

*Sydney Local Health District's RPA Virtual Hospital* (rpavirtual), the first virtual hospital in Australia, operates within a connected digital ecosystem that supports remote patient monitoring, real time analytics, and virtual care, with strong ties to the University of Sydney and other university partners. This integrated model reduces hospitalisations, enables earlier clinical interventions, and improves patients' overall experience of care (Moore et al. 2020; Raffan et al. 2021)

High-quality, timely data is essential for informed decision-making in healthcare. However, much of the data generated across the system remains fragmented and underused (Basile et al. 2025).

HREPs offer a strategic solution by aligning data and digital infrastructure across organisations, embedding analytics and decision-support closer to where care is delivered, and enabling more coordinated, evidence informed practice.

Studies show that digital platforms improve access, diversity and engagement in health research, enhancing data quality and promoting more equitable participation (Klein et al. 2025).

Strategic, whole of HREP data and digital approaches equip health systems to:

- measure what matters most to patients
- make smarter, evidence-driven decisions
- foster continuous learning and improvement
- deliver care that is efficient, equitable and sustainable

By embedding data and digital infrastructure as core foundational pillars, not add-ons, HREPs are well positioned to lead the transformation toward a future-ready LHS.

**The patient care journey: NSW Health's Single Digital Patient Record**

NSW Health's Single Digital Patient Record (SDPR), scheduled for implementation in 2026, provides an unmatched opportunity for public healthcare in Australia to capture, integrate and act on comprehensive patient data across the entire care journey.

However, the impact of the SDPR on the health system in its entirety will be limited if restricted to public health organisations alone.

Leveraging the HREP model to enable secure data sharing across partners will realise the full value of the SDPR and accelerate system-wide benefits.

## Cross sector collaboration

Collaboration exists within the healthcare system, but it is often difficult to sustain and rarely prioritised, despite its potential to address some of the system's most pressing challenges (Jones 2025). For example, cross-sector collaboration has been shown to significantly enhance population health and equity by integrating diverse social determinants of health into care delivery (Alderwick 2021); and when collaboration is not prioritised in system design, this potential is lost.

HREPs provide a compelling solution by bringing together health, research, education and industry within a single collaborative environment. They create dynamic entities (laboratories) for policy and practice, enabling governments to pilot reforms based on real-world data and frontline insights. Continuous feedback loops support rapid iteration and adaptation, advancing the goals of value-based health care.

Cross-sector collaboration also drives resource efficiency. By aligning service delivery, education, and research priorities, organisations can share infrastructure, expertise, and data, minimising duplication and improving utilisation (Amri et al. 2022)

Co-location accelerates innovation by bringing researchers and clinicians together, shortening the time from idea to implementation. Embedding co-located academic roles within hospitals and integrating medical research institutes (MRIs) leads to faster adoption of innovation (Proctor et al. 2021; McGuiver et al. 2024).

**Medical Research Institute (MRIs) and HREPs**

The Kolling Institute, a joint venture MRI between the University of Sydney and Northern Sydney Local Health District co-located at Royal North Shore Hospital enables rapid bench-to-bedside translation, including expanded clinical trials, accelerated diagnostics research, and integrated clinician-scientist roles.

Similar success is seen at the Melbourne Academic Centre for Health (MACH), where partnership between Monash University and a number of hospitals has resulted in measurable improvements in patient outcomes through collaborative research.

HREPs foster both formal and informal collaboration. Formal governance arrangements help align partners to shared vision and strategic priorities, while physical proximity enables informal, day to day interactions that drives innovation, replicating the proven benefits of collocated 'innovation precincts' where creative synergies emerge spontaneously (Amri et al. 2022).

However, despite their clear value proposition, HREPs remain difficult to establish in Australia, with a range of structural and systemic barriers impeding their development.

# Barriers to establishing HREPs in Australia

## Definition - What a HREP is not

Across the health system, the term *Precinct* is gaining traction in Australia, but without a formal definition, its meaning remains ambiguous. This lack of clarity creates significant challenges: policymakers struggle to design targeted frameworks, funders hesitate to invest, and stakeholders are left without a common language.

Most importantly, the absence of a clear definition risks conflating different models and undermining the unifying and value-achieving potential of what HREPs can truly offer. A similar phenomenon was experienced when attempting to define 'University Precincts', as articulated by the Department of Industry, Innovation and Science (Department of Industry, Innovation and Science, 2018).

Other health, research and education partnerships in Australia exist on a spectrum from informal collaborations between clinicians and universities, to more structured alliances between health services, universities, and Medical Research Institutes (MRIs). Some operate as time-bound projects and others as enduring partnerships. While each model plays a role in improving care, they cannot be considered as HREPs.

Academic Health Science Centres (AHSCs) and Research Translation Centres (RTCs) come closest in purpose. These are formally recognised consortia of healthcare, research and academic institutions committed to evidence-based healthcare and education.

But critically, they are not physically co-located. Spread across large geographic areas, they can struggle with knowledge mobilisation (Edelman et al., 2022) and lack the daily integration and spontaneous collaboration that co-location fosters, an essential hallmark of the HREP model.

Likewise, HREPs differ from traditional *innovation precincts* or *science parks*, which are primarily driven by economic development. These precincts, often anchored by technology or start-up industries, may include a health partner, but their focus is not health system improvement. With no shared governance, aligned purpose or clinical presence, their value to health transformation is limited (Montalbano & Baily, 2018; Tan et al., 2020).

HREPs also stand apart from *health villages* or *holistic health precincts*, which focus on the co-location of multidisciplinary primary care services, not the integrated presence of health, research and education institutions working in concert to drive system transformation (Oprescu et al., 2023).

While these models offer insights – AHSCs and RTCs can inform network collaboration, and traditional precincts demonstrate the benefits of clustering – none embody the full vision of a HREP where strategically aligned partners work together with a shared vision to deliver integrated care, accelerate translational research, build workforce capability, improve health system performance and drive value (Alfred Research Alliance 2025; Campbelltown Health & Education Precinct 2025)

Until a clear, consensus-driven definition of HREPs is established by national stakeholders and formally recognised by State and Federal

agencies, investment will remain fragmented, policy design will lack focus, and their true potential will go unrealised. Ambiguous concepts and 'policy language' can undermine strategic dialogue and hinder effective implementation. Clarity is not optional, it is fundamental to achieving meaningful and measurable policy impact (Alvesson and Blom, 2022).

## Absence of a strategic framework

Despite annual government and non-government investment of approximately $6.3 billion in medical research, as of 2025, Australia lacks a cohesive national strategy to guide the effective allocation and use of these funds. (AAMRI 2021).

In the absence of a national or jurisdictional strategy to guide HREP development, existing entities across Australia operate in isolation of each other, and efforts become fragmented or duplicated, creating inefficiencies and lost opportunities.

These issues are compounded by shared goals, consistent performance indicators, and uncoordinated infrastructure resulting in even the most promising initiatives struggling to connect with broader system reform (Department of Industry, Innovation & Science 2018).

The Australian Productivity Commission's 2025 interim report into the *Delivering Quality Care More Efficiently* inquiry, has emphasised that systemic transformation, such as the shift to value-based, integrated care, requires strategic enabling architecture that spans across sectors.

Yet, HREPs are developed through piecemeal initiatives, often reliant on local champions or short-term funding opportunities, resulting in limited alignment to the wider health system reform agenda.

HREPs are acknowledged in some state-level strategies, such as the *NSW Health Research & Innovation Strategy (2025)*.

While state-level efforts reflect strategic intent, they remain largely siloed, with limited integration into national initiatives. This disconnect is understandable, as the development of a cohesive, cross-jurisdictional HREP strategy should be a Commonwealth responsibility

A national strategic framework for HREP development – agreed upon and governed by State and Federal governments and embodied within the strategies of both – would provide the scaffolding to guide vision, align efforts, and harmonise resources across jurisdictions and sectors amplifying the potential impact of each precinct.

A national framework also has the capacity to deliver VBHC by:

- Accelerating research translation into real-world practice, enhancing health outcomes
- Improving patient experience through seamless service integration
- Supporting workforce experience and capability through structured learning and collaboration
- Delivering cost efficiency by minimising duplication and targeting impact
- Advancing equity by ensuring that all regions can benefit

## Fragmented implementation

Across the country, individual healthcare providers, research institutes, and universities are actively pursuing improvements in LHS and

VBHC. While many initiatives are promising, they frequently operate in silos disconnected from one another and from system-wide strategies. It has been observed that these uncoordinated approaches and resulting innovations are often 'rich in intent but poor in scale' (Ipsen and Sheppard, 2024), lacking pathways for knowledge sharing or spread.

Similarly, siloed, place-based collaborations have struggled to integrate their findings into broader policy frameworks due to an absence of alignment mechanisms (Peiris et al., 2024).

HREPs can help bridge gaps between research, education, and care delivery, but their potential will only be realised through a coordinated strategy that connects local innovation to a national learning health system.

In New South Wales, to address system fragmentation, the NSW Health Office for Health and Medical Research (OHMR) is leading efforts to connect and coordinate HREPs across the state. Responsibility for precincts within NSW Health was recently transferred from Health Infrastructure NSW to OHMR, acknowledging a strategic shift and recognition that precincts are not about infrastructure alone. While these are promising steps, national coordination remains absent.

In the absence of a unifying strategy, interstate competition for funding—and long-standing rivalries—may pose greater barriers to collaboration than international engagement.

## Disjointed metrics and governance

Meaningful data integration and partnership performance are hindered by governance issues and a lack of common metrics (Frean et al., 2024).

Even the most promising HREP risks losing momentum without clearly defined strategic direction and measurable outcomes to guide their development and assess impact.

For example, within each HREP, each partner organisation operates under a different set of priorities and performance drivers. Health services are often guided by clinical outcomes, safety, and throughput metrics. Universities focus on enrolments, student experience, and research outputs. MRIs track success through grant income, publications, and citations. Such divergent indicators make cross-sector alignment challenging and dilute the shared value proposition of HREPs.

Moreover, by undermining collaboration, the ability to track progress or demonstrate impact at scale is limited.

These issues are demonstrated at the national level through the Australian Commission of Safety and Quality in Health Care's (ACSQHC) Fourth Atlas of Healthcare Variation 2021 which reveals significant disparities in data reporting and quality across jurisdictions. Likewise, the Productivity Commission points to inconsistent measurement and incompatible reporting frameworks as major barriers to system learning and improvement (Productivity Commission, 2023).

To enable system-wide transformation, a unified performance and governance framework is needed. This framework should be able to facilitate cross-sector learning, support benchmarking across precincts, and align HREP activity with national priorities. Without this, even our best-efforts risk

remaining disconnected, difficult to evaluate, and ultimately unsustainable.

### Data silos and limited interoperability

At the core of any LHS lies data: data to monitor outcomes, inform decisions, and enable continuous learning. Yet in most precinct settings, data remains trapped in organisational silos, constrained by incompatible platforms and inconsistent privacy protocols.

Integrated, real-time data is fundamental to the LHS model (Enticott et al. 2021), where data becomes knowledge, knowledge becomes performance, and performance generates new data (Friedman et al. 2017). Without integration, this continuous cycle breaks down, limiting the ability of HREPs are to harness analytics, identify system gaps, predict outcome, drive translational research and embed value within the system.

A national HREP framework must therefore consider digital architecture standards and mechanisms for ethical, interoperable data sharing across sectors, with appropriate governance to manage risk and promote trust.

**Illustrative Scenario**

Local hospitals collect rich clinical data, such as patient outcomes, diagnostics, and treatment pathways, through their Electronic Medical Record (eMR) systems. However, this valuable data often remains siloed, limiting its broader strategic and research use.

Meanwhile, the partnering university holds complementary datasets from research trials and public health studies, and the vocational education provider collects data on student placements and workforce readiness.

Despite the collective value of these datasets, they are stored in separate systems that don't talk to each other.

The hospital's eMR is incompatible with the university's research data repository, and there is no shared data governance framework to allow linkage. Privacy protocols differ between institutions creating further barriers.

As a result, research findings cannot easily be tested or applied in the clinical setting, patient outcomes cannot be tracked across services or providers, and workforce planning cannot be informed by real-time service data.

Opportunities for real-time feedback loops, essential for a functioning LHS are lost.

### Translation of evidence into practice is slow

The promise of HREPs lies in their ability to bring evidence closer to action. Yet, across Australia, translation of research into clinical and policy practice remains slow and inconsistent. As infamously noted, the average time for evidence to reach clinical practice is 17 years (Morris et al. 2011).

Despite significant investment in research and service reform, there is no consistently applied mechanism for embedding evidence into clinical workflows or operational models at scale. Spread and scale-up are difficult due to a lack of coordinated capability, feedback loops, and accountability structures needed to translate insights into sustained practice change (Greenhalgh & Papoutsi, 2019), reflecting a system design gap, not a failure of knowledge generation.

However, progress has been made through embedding research into practice through shared appointments, joint research projects,

and collaborative governance models, for example at the Kolling Institute in NSW and the Melbourne Academic Centre for Health in Victoria.

Building on this, HREPs have the ability to offer an environment where coordinated and consistent approaches are systematised and embedded nationally.

### Redundant pilots and programs

Without central coordination or real-time knowledge sharing between HREPs, organisations frequently develop pilots and programs in isolation, often targeting the same healthcare challenges without the benefit of shared learning or alignment.

This is especially evident in initiatives focused on hospital readmissions, chronic disease management, or digital health integration, which are often implemented without visibility of, or coordination with, similar efforts underway elsewhere.

The Australian Government has acknowledged concerns about duplication between national medical research funding streams, namely the Medical Research Future Fund (MRFF) and the Medical Research Endowment Account (MREA), stemming from fragmented and unaligned governance (Australian Government, 2023). As a result, consultation has occurred to improve alignment and ensure the Australian community obtains the greatest benefit from this investment in health and medical research. As a result of this consultation, the Australian Government is developing a National Health and Medical Research Strategy to provide national direction and alignment in health and medical research. This strategy is due to be published in 2026.

Virtual care initiatives are a good example of duplicative pilot programs. Multiple health services across Australia have implemented virtual care and hospital-in-the-home pilots with slightly different methodologies but aimed at solving the same problem (NSW Agency for Clinical Innovation 2024; Newton et al. 2024). These parallel initiatives are rarely evaluated against shared metrics or designed for interoperability, making it challenging to compare outcomes or synthesise learnings across programs.

Such duplication consumes valuable time and public resources and can create unnecessary competition between institutions for recognition or funding. This further discourages collaboration, diminishing the potential for scale.

The Australian Health Research Alliance (AHRA) has repeatedly called for shared platforms to coordinate research activity and enable cross-site learning. AHRA has played a pivotal role in the Health Studies Australian National Data Asset (HeSANDA) program led by the Australian Research Data Commons (ARDC) to allow researchers to access, share, and reuse data from health studies, including clinical trials. It is this coordinated approach and visibility of pilot programs that is required to avoid duplication and ensure broad system efficiency.

### Missed opportunities for scale and cross-sector collaboration

HREPs have demonstrated potential to deliver tangible improvements, including new models of care, innovative data tools, and interprofessional education programs. However, these innovations are often limited to their organisations of origin, and when

scaled, the process is typically slow and fragmented (Scarbrough & Kyratsis 2022).

Valuable insights into clinical, operational and strategic innovations often remain siloed, captured in internal reports, academic publications, or standalone conference presentations, without the necessary infrastructure or mechanisms needed to support system-wide uptake and impact (Lau et al., 2024). This failure to translate and spread successful innovations is, at best, a missed opportunity and at worst, a systemic failure that compromises health outcomes and equity.

Collaboration between HREP partners often succeeds despite, not because of, existing structures. Structural barriers, such as misaligned policies, funding mechanisms and accountability frameworks continue to hinder effective collaboration and slow the pace of joint innovation.

Industry collaboration with HREPs faces comparable challenges. Inconsistent and duplicative processes, such as varying legal frameworks, ethics approvals, intellectual property arrangements, and partnership protocols, creating barriers to meaningful industry engagement. This complexity discourages investment and hampers the commercialisation of innovations with the potential to scale (Industry, Innovation and Science Australia, 2023).

A coordinated national framework, that streamlines cross-sector engagement, aligns protocols, and articulates a shared vision is required to unlock the full potential of HREPs.

## Competing reporting and measurement frameworks

Competing frameworks undermine the core purpose of HREPs by hindering integration, diluting shared impact, and disrupting coordinated system improvement. This results in:

- partners not working toward the same goals
- fragmented accountability and, difficulty demonstrating, and defencing, the transformative potential of HREPs
- reduced efficiency as a result of partners reporting in multiple formats to multiple stakeholders
- disruption to the learning cycle as a result of incompatible metrics preventing comparison, benchmarking, and coordinated improvement

Competing reporting and measurement frameworks also create a significant administrative burden and inefficiencies in research grant reporting (Schiller and LeMire, 2023). Similar studies have identified burdensome reporting in the healthcare sector (Zegers et al. 2022). When combined in the HREP setting, this disparate and accumulative reporting adds up, diverting resources from delivering care, advancing research, or contributing to education.

At the core of the issue is the misalignment of key performance indicators across HREP partners. As long as each partner is driven by different reporting requirements and funding justifications, efforts will remain fragmented, with partners pulling in divergent directions rather than towards a unified goal.

Such fragmentation also impedes policy evaluation and system learning.

A lack of national consistency in measurement frameworks severely limits our ability to monitor reform progress, identify inequities, or benchmark best practice (Productivity Commission, 2023). This is particularly evident in HREPs, where reporting is often self-determined and lacks a consistent objective basis for measuring collective successor impact. As a result, achievements are typically limited to individual partner contributions within their own domains, rather than reflecting the HREPs overall performance.

A unified strategy for measurement within HREPs would reduce duplication, enable more robust evaluations, and focus attention on outcomes that matter to patients, communities, and systems.

Enhanced HREP coordination and governance aids in the delivery of VBHC by supporting:

- Improved health outcomes through shared learning and data-driven care
- Enhanced patient experience through coordinated service delivery and rapid implementation of innovations
- Workforce wellbeing by reducing administrative burden and fostering inter-professional mobility
- Greater cost efficiency through shared infrastructure, tools, and support services
- Equity by enabling consistent access to high-quality care and innovation regardless of location

## Lack of strategic investment hinders HREP development

> 'Government support for health and medical research underpins the nation's health and prosperity – directly by providing the evidence base for improved healthcare and health-related policy, and indirectly by reducing the burden of ill health on society and the economy and by stimulating new economic activity' (Australian Government, 2023).

HREPs have the potential to deliver integrated, high-value care and drive innovation across Australia's healthcare system. However, fragmented and short-term funding, misaligned with their long-term, cross-sectoral objectives, remains a significant barrier to their sustainability and impact. Without a coordinated, strategic approach to investment, the transformative potential of HREPs will remain underutilised.

Instead, financial support for HREPs is largely opportunistic, shaped by discrete grants, infrastructure programs, or local economic priorities rather than guided by an overarching vision or national health reform agenda.

For example, while the MRFF has supported numerous initiatives within or adjacent to HREPs, there is no dedicated funding stream for precincts as holistic, integrated entities. Funding is often awarded to specific research projects or thematic priorities, without supporting the broader systems, structures, and capabilities that make a precinct function.

As a result, even the most promising HREPs struggle to secure the operational funding required to coordinate partnerships, maintain shared governance, embed translation pathways, or invest in long-term infrastructure.

The absence of coordinated investment limits HREPs' capacity to contribute to broader system priorities, including workforce development, digital health integration, and improved equity of access.

Two core financial barriers facing Australian HREPs and innovation precincts more broadly have been identified by The NSW Innovation and Productivity Council's report *NSW Innovation Precincts – Lessons from International Experience* (NSW Innovation and Productivity Council, 2018):

- a lack of seed capital, and
- over-reliance on time-limited public funding.

This short-term, unstable and piecemeal funding environment limits the ability to foster the long term cultural and structural change essential for mature, high impact HREPs.

For example, while some precincts, like the Randwick Health & Innovation Precinct and Liverpool Health & Academic Precinct, have received capital investment through health infrastructure programs, such as the Victorian Health Building Authority or NSW Health Infrastructure, funding for essential 'soft' elements such as data infrastructure, workforce capability-building, and partnership coordination remains scarce.

Indeed, for every dollar of research funding, an additional 56 cents is needed to cover indirect research costs (AAMRI, 2021). This shortfall reflects the broader underinvestment in the less visible, but essential, capabilities needed to support integrated, translational health systems, such as research infrastructure, data management, commercialisation, and administrative support.

The transfer of precinct responsibility in NSW Health from Health Infrastructure NSW to the OHMR, reflects a growing recognition that HREPs are more than just physical infrastructure, however, dedicated and sustained funding to support their full potential remains lacking.

The absence of a unified and strategic investment model undermines confidence and discourages meaningful engagement from the private sector and philanthropic investors.

Australia needs coordinated investment aligned with national health and innovation goals, supporting the long-term development and scaling of collaborative precinct models.

> Donors and investors are more likely to contribute when there is clear alignment with long-term strategy, reliable government co-investment, and robust mechanisms for tracking and reporting impact. In the absence of this clarity and coordination, investment risks appear too high and return too uncertain (Philanthropy Australia, 2025)

## Short-term investment undermines long term impact

HREPs, and the shift to VBHC, are inherently long-term endeavours, with sustained investment in medical research serving as a cornerstone for effective healthcare research and translation (AAMRI, 2021).

The consequences of short-termism are clear in programs that show strong early outcomes

but falter over time due to a lack of sustained support. It has been identified that many programs showing promise lack sustainability due to inadequate leadership and support, limited ongoing funding, insufficient resourcing, and limited long-term planning (Zurynski et al. 2023).

The impact of short-term funding cycles as a fundamental barrier to realising returns on government investment in research and innovation ecosystems could be mitigated by. transitioning toward multi-year, place-based funding approaches that reflect the complex, long-term nature of integrated innovation platforms like HREPs (Industry Innovation and Science Australia, 2024)

Longer-term investment would also allow HREPs to pursue strategic workforce planning, expanding clinical training pathways, fostering interprofessional learning environments, and embedding continuous professional development into health service delivery.

Internationally, the value of longer-term funding approaches is being realised. For instance, the UK's National Institute for Health and Care Research (NIHR) funds Biomedical Research Centres with long-term, structured investment aimed at supporting integrated research and care delivery. These centres serve as hubs for workforce development, industry engagement, and translational research, a position analogous to those envisioned for Australian HREPs.

Solving the HREP funding situation will deliver on VBHC through:

- Improved health outcomes through faster translation of research into care
- Better patient and provider experiences through sustainable innovation-driven service delivery
- Cost efficiency through streamlined research and care integration
- Greater equity by supporting HREP development in diverse regions

# Conclusion and Recommendations

HREPs represent a critical yet underutilised opportunity to embed VBHC and LHS principles into the fabric of Australia's health system. By integrating clinical care, research, education, and industry, HREPs create high-performing, place-based ecosystems that accelerate innovation, foster continuous learning, and deliver measurable system impact.

HREPs operationalise VBHC by:

- Improving health outcomes through rapid adoption of evidence-based practices.
- Enhancing patient experience via integrated, person-centred models of care.
- Supporting provider experience through collaborative, learning-oriented cultures.
- Driving cost efficiency by reducing duplication and optimising service delivery.
- Promoting equity through inclusive design and locally responsive innovation.

Despite their potential, Australia's approach to HREPs remains fragmented, lacking a unified vision, consistent policy, and sustained investment. Without national leadership, HREPs risk being treated as isolated local projects rather than strategic platforms for system-wide transformation.

To unlock the full value of HREPs and embed VBHC and LHS principles at scale, four key actions are recommended:

## 1. Develop a Nationally Consistent Definition

The development of a nationally endorsed definition of an HREP, underpinned by a common terminology, should be led by the Department of Health, Disability and Aged Care, or alternatively coordinated through an established intergovernmental mechanism such as the National Health and Medical Research Strategy Interdepartmental Committee (IDC), in close consultation with state, territory, and local HREP stakeholders. A uniform definition of HREPs will:

- Align stakeholders across sectors and jurisdictions.
- Inform governance, investment, and performance frameworks.
- Differentiate HREPs from adjacent models.
- Enable benchmarking, shared learning, and scalable replication.

## 2. Develop a National Strategic Framework

A National Strategic Framework for HREPs must developed, and embedded, within the broader National Health and Medical Research Strategy. This integration will ensure HREPs are recognised as core infrastructure for research translation, workforce development, and system innovation. The framework should define:

- Core principles and minimum standards for HREP development.

- Governance, data infrastructure, funding, and workforce requirements.
- Integration of VBHC and LHS as foundational pillars.

### 3. Establish National Coordination and Governance

A formal mechanism is required to connect HREPs into a cohesive, learning network. National coordination would:

- Harmonise governance arrangements and reduce administrative barriers.
- Enable shared infrastructure, metrics, and data frameworks.
- Strengthen collaboration across institutions and jurisdictions.

To achieve this, it is recommended that a dedicated sub-committee be established under an existing intergovernmental body, such as the Inter-Governmental Policy Reform Group (IGPRG) or the National Health and Medical Research Strategy Interdepartmental Committee (IDC).

This sub-committee should include senior representatives from state and territory health departments, medical research leaders, and relevant national agencies. Its functions would be to:

- Align HREP development with national priorities.
- Standardise governance and data frameworks.
- Facilitate shared learning and knowledge exchange across jurisdictions.

Establishing such a mechanism will move HREPs from fragmented initiatives to a nationally integrated system, capable of driving health system innovation.

### 4. Identify and Allocate Sustained Financial Investment

Strategic, long-term funding is essential to move HREPs from promise to driving VBHC. Investment should:

- Prioritise initiatives aligned with VBHC and LHS principles.
- Encourage co-investment from government, academia, industry, and philanthropy.
- Support indirect costs, including operational needs, governance, data integration, and capability-building.

Innovation and initiative-based funding for HREPs could be sourced through several avenues:

- Strategic Prioritisation: Align existing funding streams, such as the MRFF and the NHMRC, to prioritise initiatives undertaken by HREPs.
- Reallocation of Existing Resources: Repurpose a portion of MRFF and NHMRC funding to specifically target HREP-related innovation and collaboration.
- Establishment of Dedicated Funding: Create a new, purpose-built funding mechanism to support the long-term development and impact of HREPs.

Operational funding should be addressed through dedicated budgets provided by state-based operators, typically the relevant Ministry or Department of Health. To ensure financial sustainability and shared responsibility, HREPs should also consider implementing a membership-based funding

model, whereby HREP partners contribute equitably to operational costs. This approach would help to avoid placing the full financial burden on the state government, while recognising that all partners benefit from the HREP infrastructure, services, and collaborative opportunities.

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