



Rethinking system stewardship in Australia's mental health system

Addressing the structural consequences of fragmentation and decentralised reform

December 2025

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Acknowledgement of Country

KPMG acknowledges Aboriginal and Torres Strait Islander peoples as the First Peoples of Australia. We pay our respects to Elders past, present, and future as the Traditional Custodians of the land, water and skies of where we work.

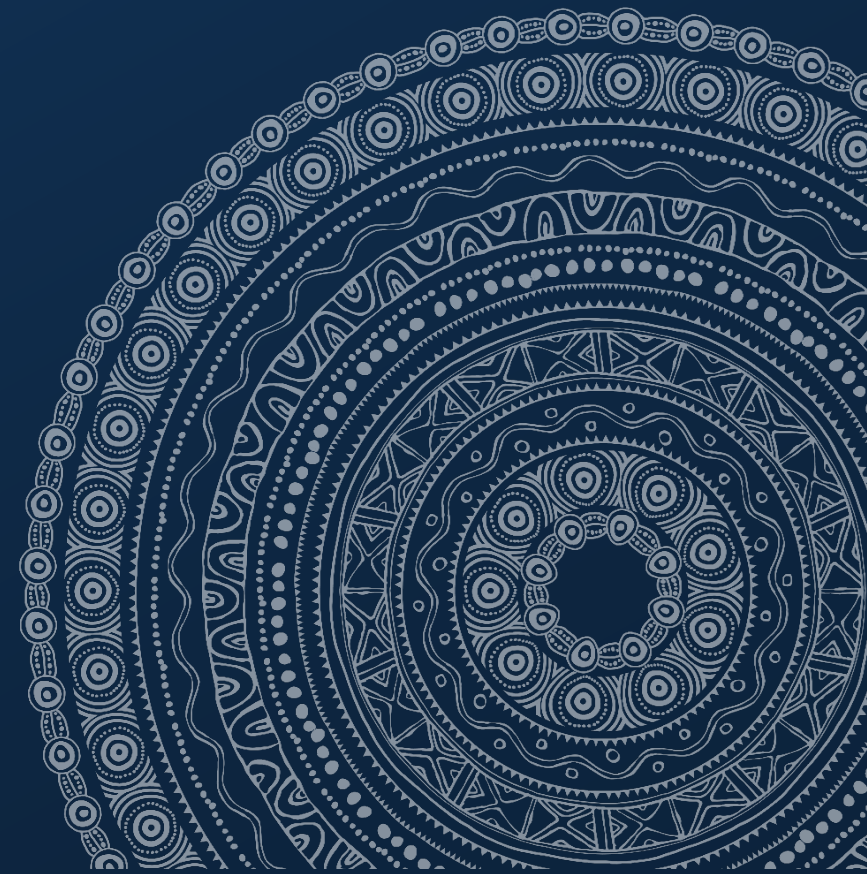
At KPMG, our future is one where all Australians are united by a shared, honest, and complete understanding of our past, present, and future. We are committed to making this future a reality. Our story celebrates and acknowledges that the cultures, histories, rights, and voices of Aboriginal and Torres Strait Islander People are heard, understood, respected, and celebrated.

Australia's First Peoples continue to hold distinctive cultural, spiritual, physical and economical relationships with their land, water and skies. We take our obligations to the land and environments in which we operate seriously.

Guided by our purpose to 'Inspire Confidence. Empower Change', we are committed to placing truth-telling, self-determination and cultural safety at the centre of our approach. Driven by our commitment to achieving this, KPMG has implemented mandatory cultural awareness training for all staff as well as our Indigenous Peoples Policy. This sincere and sustained commitment has led to our 2021-2025 Reconciliation Action Plan being acknowledged by Reconciliation Australia as 'Elevate' – our third RAP to receive this highest level of recognition. We continually push ourselves to be more courageous in our actions particularly in advocating for the Uluru Statement from the Heart.

We look forward to making our contribution towards a new future for Aboriginal and Torres Strait Islander peoples so that they can chart a strong future for themselves, their families and communities. We believe we can achieve much more together than we can apart.

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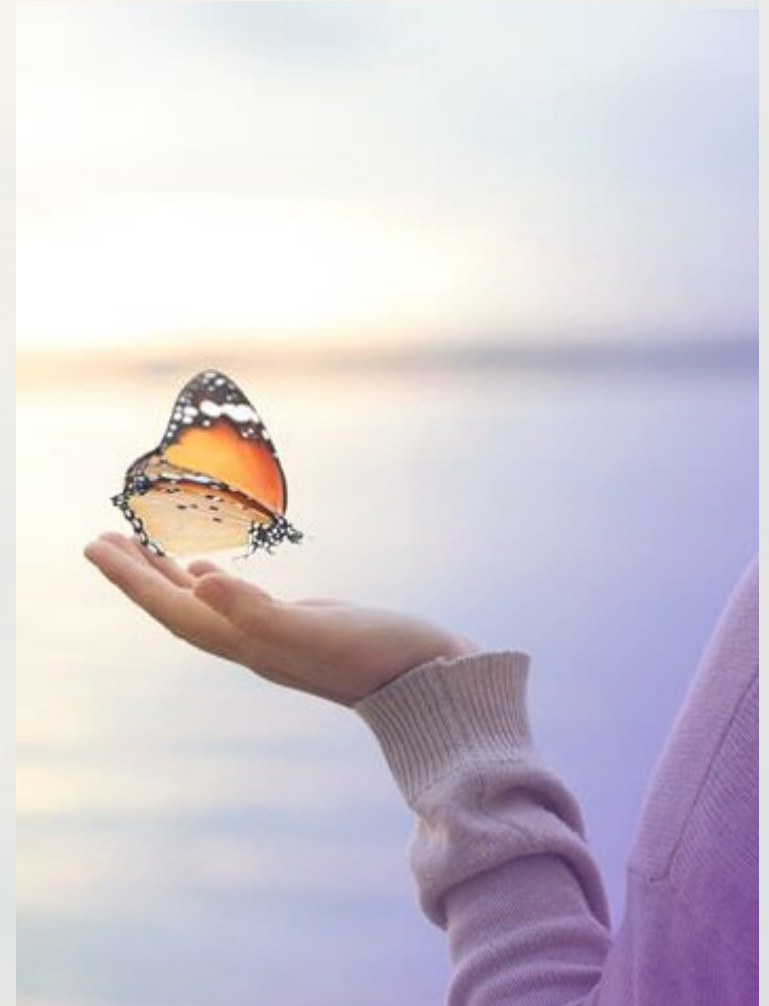


Recognition of lived and living experience

KPMG recognises and deeply values the insights of individuals with lived and living experience of mental health challenges. Your experiences provide essential perspectives that shape a deeper understanding of the complex realities faced by individuals, families, and communities across Australia.

We acknowledge the courage and resilience of those who share their stories, as well as the ongoing efforts of individuals navigating these challenges. Your voices are critical in guiding informed policy, service design, and decision-making processes to build a more inclusive and supportive mental health and wellbeing system.

In preparing this paper, we have endeavoured to reflect these lived experiences in ways that amplify their significance, ensuring they remain central to the narrative. We are committed to continued collaboration with individuals and groups with lived and living experience as part of an inclusive approach to improving mental health outcomes for all Australians.



Contents

Introduction	6
Misaligned system design	7
The policy failure of decentralisation without oversight	8
Commissioning and the myth of ‘shared risk’	11
The governance gap: No one is driving true integration	12
Redesigning the system: Where do we go from here?	13
Conclusion: Governments must take back system leadership	17
About KPMG’s Healthcare practice	18
Article contributors	19

Rethinking Australia's mental health system: A thought leadership series

Mental health in Australia is facing both immense challenges and compelling opportunities for reform. For decades, there have been ongoing efforts to improve the nation's mental health system, yet persistent systemic issues continue to hinder its effectiveness and sustainability. The gap between what people need and what the system delivers is stark. Despite significant investment and reform, demand continues to exceed supply, and accessing care can be overwhelming, fragmented, and inconsistent.

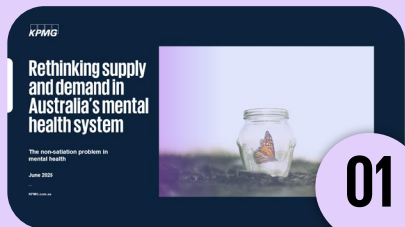
At the heart of this two-part series is a recognition that the way forward lies in bold, systemic action. To transform Australia's mental health system, we must move beyond incremental and reactive reforms, toward integrated solutions that address structural disadvantage, prioritise prevention, and enable people to access timely and effective support across the care continuum. By focusing on these themes of systems design and structural determinants, this thought leadership series aims to contribute to the critical national dialogue on the future of Australia's mental health system—and to galvanise the transformative change needed to create a system that is truly equitable, sustainable, and person-centred.

System reform through digital transformation: A further thought leadership series

This initial series will be followed by a four-part series focused on supporting sustainable system reform in mental health, focusing on lasting and impactful digital transformation. This will include:

- The case for digital transformation
- Planning for digital transformation
- Enablers of change for digital transformation
- Roadmap for digital transformation

This series includes the following:



01

Rethinking supply and demand in Australia's mental health system

Part one



02

Rethinking system stewardship in mental health

Part two (this paper)

Our mental health system is fragmented by design

But who is responsible?

The mental health system stands at a crossroads.

For decades, Australia's mental health system has been shaped by well-meaning reforms that prioritised decentralisation, flexibility, and consumer choice.

Yet, these very decisions have inadvertently created a fragmented ecosystem, leaving consumers, providers, and policymakers to navigate a system plagued by inefficiencies and disjointed care pathways.

For consumers, this fragmentation is felt acutely. Multiple entry points, repeated triaging, and disconnected services mean that accessing support can feel overwhelming and disempowering. Providers also struggle under this design, unclear on their role in managing risk while grappling with rigid funding models that hinder collaboration. Meanwhile, governments, in their efforts to foster local innovation, have unintentionally reinforced silos that prevent integration and coordination across the system.

The result is a system where accountability is diffuse, risk is pushed to those least equipped to bear it, and the promise of seamless, person-centred care remains unfulfilled.

At this critical juncture, we must ask the hard questions:

- **Who is ultimately responsible for the coherence of this system?**
- **Are current commissioning and risk allocation models fit for purpose?**
- **And if not, what governance paradigm can drive the transformation needed to deliver on the promise of equitable, accessible, and integrated mental health care?**

This paper explores these questions, challenging conventional assumptions about risk and accountability while proposing bold solutions to redesign Australia's mental health system for the future.



The system is designed around funding, not consumers or outcomes



At its core, Australia's mental health system is not designed around the people it serves. It is designed around funding structures. The availability and configuration of services are shaped less by the realities of consumer need and more by the fragmented architecture of government funding cycles, grants, and commissioning agreements.

This fragmentation is particularly evident in primary mental health care, where both the Commonwealth and State governments contribute. In Victoria, for example, Commonwealth-funded services delivered through Primary Health Networks (PHNs) operate alongside state-funded programs, each with their own commissioning bodies, eligibility rules, reporting requirements, and service expectations. While the intention is to enable local responsiveness, in practice it results in a highly congested landscape that is difficult to navigate, not only for consumers, but for clinicians and referrers as well.

This complexity poses real barriers to continuity of care. Acute services often struggle to confidently refer people back into community or primary services due to unclear pathways, limited availability, or uncertainty about service scope and quality. Consumers, meanwhile, are frequently bounced between programs, forced to retell their story, and subjected to repeated assessments because data systems are not interoperable.

Instead of fostering integration, current funding and commissioning arrangements can reinforce siloes. Tools that should simplify access — such as digital navigation platforms, service directories, and referral pathways — are often developed in parallel rather than in connection. As a result, consumers can experience a system that feels fragmented, inconsistent, and indifferent to their journey.

This friction is not incidental. It is a structural consequence of a system built around funders and contracts rather than around people. Addressing this misalignment and creating pathways that support shared accountability and coordinated care, is essential to building a mental health system that is coherent, equitable, and responsive at every level.

We must ask:



Should commissioning flexibility be constrained by a stronger national governance framework?



If funding structures continue to reinforce system fragmentation, does the government have a responsibility to intervene?



How do we ensure that mental health services are designed not for the ease of funders, but for the people who need them most?

The policy failure of decentralisation without oversight

Instead of driving genuine reform, decentralisation has led to layer upon layer of uncoordinated investments, each tackling the same problems in isolation.

Lack of co-ordination in governance and system integration

Governments have long championed decentralisation as a way to increase responsiveness and local innovation in mental health services. In theory, devolving decision-making to regional bodies should allow for more tailored, community-driven solutions. In practice, however, decentralisation has occurred without clear accountability mechanisms – leading to policy drift, inefficiencies, and unnecessary duplication of effort.

The lack of a centralised governance framework means that different regions are independently building digital referral tools, service directories, and navigation platforms – often funding identical solutions multiple times. Instead of scaling successful models across the system, new funding rounds frequently commission entirely separate, parallel processes, wasting resources and deepening fragmentation. Even when providers develop system-wide solutions, there is no mandate to consolidate and integrate these efforts, leading to a patchwork of disconnected tools rather than a seamless system.

The real question is: Why isn't there a single, coordinated approach to system integration?

At what point does the government step in?



Should State and Commonwealth Governments impose stricter commissioning guidelines to prevent inefficiencies and ensure that investments actually improve system-wide coherence?



If we are serious about reducing fragmentation, does decentralisation as we know it need to be rethought?

The limits of decentralisation in mental health commissioning

Over the past decade, decentralisation has been promoted in mental health reform as a pathway to innovation, responsiveness, and person-centred care. In theory, local commissioning structures, like Australia's Primary Health Networks (PHNs), should be well placed to tailor services to regional need and drive integration across local service ecosystems. In practice, however, the evidence suggests that decentralisation without strong governance, shared accountability, and system-wide architecture often leads to fragmentation, duplication, and a shifting of risk rather than its true redistribution.

Australia's experience: Disconnection, not integration

The 2015 transfer of primary mental health funding from Medicare Locals to PHNs was a key moment in the decentralisation of Australia's mental health system. The stated aim was to enable more regionally responsive planning and delivery. However, multiple evaluations and reports, including those by the National Mental Health Commission (NMHC), the Australian National Audit Office (ANAO), and the Productivity Commission, have found that the reform did not improve system integration or outcomes at scale.^{1,2,3}

The Productivity Commission's Mental Health Inquiry Report (2020) concluded that decentralised governance had contributed to a system that is not "person centred", difficult to navigate, and often does not empower those who need it most.

The Commission specifically cited poor coordination between PHNs and state-funded services, variable commissioning capability, and short-term, inconsistent contracting as barriers to sustainable reform.

Consumers frequently reported that no one part of the system felt accountable for their care. As a result, individuals, particularly those with complex or intersecting needs, fell through service gaps.

“ Australia's mental health system does not empower those who need it... Put simply, Australia's mental health system is not 'person-centred'. It should be. ”⁴

¹ Productivity Commission. (2020, Jun 30). Mental Health Inquiry Report.
² National Mental Health Commission. (2021, n.d.) National Report: Monitoring Mental Health and Suicide Prevention Reform.
³ Australian National Audit Office. (2024, Feb 27). Effectiveness of the Department of Health and Aged Care's Performance Management of Primary Health Networks.
⁴ Productivity Commission. (2020, Jun 30). Mental Health Inquiry Report.



International comparisons: Lessons from other systems

Decentralisation is often presented as a solution to bureaucratic inefficiency and a path to “localised, person-centred care.” However, evidence from both Australia and comparable international settings shows that without structural safeguards and shared accountability mechanisms, decentralised commissioning can amplify fragmentation, risk displacement, and inequity.



Both the UK and New Zealand pursued decentralised models of mental health commissioning in an effort to improve responsiveness and local control. But without strong national coordination, each system experienced fragmentation, inequity, and a loss of strategic oversight, particularly for complex or high-needs populations.

UNITED KINGDOM

In the United Kingdom, Clinical Commissioning Groups (CCG) were responsible for planning and funding local mental health services. Over time, this led to widespread variation in service quality, short-term contracting, and incentives that favoured low-risk, high-throughput care. Strategic commissioning capacity was uneven, and integration across care pathways suffered. The NHS is now shifting toward Integrated Care Systems (ICS), a more centralised model that aims to restore coordination and long-term planning.^{5,6}

NEW ZEALAND

New Zealand took a similar path with District Health Boards (DHBs), which controlled regional mental health funding. The 2018 He Ara Oranga Inquiry found the system to be fragmented, under-resourced, and inconsistent, producing postcode-dependent access.⁷ In response, the government created Health New Zealand, dissolving the DHBs and centralising governance to deliver more equitable care across the country.

The lesson for Australia is clear: decentralisation on its own does not ensure integration. Without shared governance, robust system architecture, and accountability for outcomes, decentralised commissioning risks reproducing the very silos and inequities it seeks to overcome.

⁵ The King's Fund. (2022, Aug 19). Integrated care systems explained.

⁶ NHS England. (2019, Jan). Long Term Plan.

⁷ He Ara Oranga Inquiry. (2018, Nov). Report of the Government Inquiry into Mental Health and Addiction.

Commissioning and the myth of 'shared risk'

Governments design mental health commissioning models under the assumption that risk is shared between funders, organisations, and providers. In reality, risk is not shared. It is transferred downward, accumulating at the level of service providers, frontline clinicians, and ultimately, consumers. The further one moves through the system, the less structured risk ownership becomes, leaving those at the frontline to absorb its consequences.

The failure of current commissioning models lies in their assumed, rather than explicit, approach to risk allocation. Contracting structures prioritise activity-based funding, which rewards outputs rather than system resilience. Fixed funding models (such as block funding models or rigid Full-Time Equivalent [FTE] allocations) prevent services from scaling with real demand, forcing providers to operate within outdated forecasts rather than responding dynamically to changing needs.

Even more concerning, services are financially penalised for taking on those perceived as “high-risk consumers”, creating an environment where avoidance behaviours become a logical survival strategy. The implicit incentive is to minimise exposure to “complex cases” rather than investing in the capability and supports to manage those who most need support. In private and community mental health, where risk-sharing structures are largely absent, consumers are frequently escalated to emergency services rather than being collaboratively managed within teams.

Risk in mental health care is often framed as something to be avoided, mitigated, or transferred. But this obscures the deeper truth: some risk is necessary for growth. Whether it's trying a new coping strategy, leaving an unsafe relationship, attending a first therapy session, or learning to trust again—healing involves uncertainty.

When systems are structured to avoid risk at all costs, they often default to short-term, measurable outputs at the expense of longer-term transformation. In doing so, they unintentionally penalise providers who work with more complex or high-needs clients, and they strip consumers of the dignity to take supported, meaningful risks in pursuit of their own recovery.

The consumer is left at the bottom of this risk cascade, navigating a system fragmented by design rather than necessity—one in which responsibility is passed around but rarely owned.

If we are serious about shared risk, we must embed not only governance safeguards but also relational and developmental models of care that understand risk as part of the therapeutic process - not something to be delegated, priced, or avoided altogether.

- »» Should commissioning agreements explicitly require structured risk-sharing mechanisms rather than assuming they exist?
- »» If risk is an unavoidable element of mental health service provision, then should the government actively incentivise and embed risk-sharing frameworks into contracts, rather than allowing avoidance to become the default response?
- »» What if commissioning systems not only shared risk financially—but honoured it clinically, relationally, and ethically?
- »» Should a national mental health integration framework be introduced to prevent siloed decision-making?
- »» Without stronger policy intervention, is there any reason to expect the system to function differently in the future?

The governance gap

No one is driving true integration

Despite national aspirations for a seamless, coordinated mental health system, no single entity holds responsibility for ensuring that it operates as one. The result is structural fragmentation, where multiple funders, providers, and commissioning bodies operate in parallel, without a shared mandate or mechanism for coherence.

This fragmentation is particularly evident at the interface between acute and primary care. Transitions out of hospital or public mental health services are often precarious, with no clear mechanism for ensuring that the person is “held” once discharged. In theory, primary care and community services should step in - but in practice, these services are often unclear, unavailable, or disconnected from acute pathways. For consumers, this can mean falling through the cracks at the very point where continuity is most critical.

These challenges are compounded by overlapping jurisdictional responsibilities. The Commonwealth funds primary mental health care (via PHNs), while state governments fund public and acute services. In Victoria and elsewhere, this has led to a congested and competitive community mental health landscape, where PHN-commissioned programs exist alongside state-funded initiatives, often targeting similar populations with differing models. This “fight for the high street” reflects a deeper tension: **If mental health care is meant to function as a system, who is actually responsible for shaping it at the local level?**

The key drivers of this governance gap include:

- **Fragmented commissioning:** PHNs operate in silos, each with their own approach to service design, referral protocols, and digital infrastructure. There is no enforceable national standard, resulting in regional variability that reinforces fragmentation.
- **Disconnected service tiers:** Public mental health services remain largely separate from primary and community care, despite strong evidence supporting the benefits of integrated, stepped care models.
- **Exclusion of key social supports:** Housing, employment, disability, and justice services continue to sit outside of mental health system planning — despite their direct impact on mental health outcomes and recovery.

In the absence of a shared integration framework, consumers are left to navigate the system alone:

- They are asked to re-tell their story, re-triage, and manually connect services that should already be linked.
- Providers are locked into inflexible funding and reporting arrangements that inhibit collaboration.
- Governments continue to commission duplicative initiatives rather than consolidating or scaling what works.

This isn't simply a failure of design. It is a failure of governance. Without clearer accountability for system integration, fragmentation is not just possible. It is inevitable. The question is no longer whether coordination is needed, but whether governments are prepared to mandate it, resource it, and hold each other to account for delivering it.

Redesigning the system: Where do we go from here?

The failures of the current mental health system are not due to a lack of investment, services, or even goodwill. Instead, they stem from poor system design, entrenched fragmentation, and an approach to funding and governance that reinforces silos rather than breaking them down. If we are to build a functional, integrated, and consumer-centred mental health system, we need to move beyond incremental tweaks and towards structural reform.

Commissioning reform: From activity-based funding to demand-responsive models

At present, mental health commissioning models are structured around provider activity rather than system outcomes. Services are funded based on pre-defined outputs, such as sessions delivered or consumers seen, without a mechanism to ensure that these activities translate into long-term improvements in system performance or individual wellbeing.

A new commissioning model should:

- Align funding with population demand and system goals, rather than fixed staffing or activity inputs, enabling services to flex resources, adjust delivery models, and respond to local needs as they change over time.
- Incentivise collaboration over competition, so that service integration and shared accountability become system priorities, not afterthoughts.
- Embed enforceable expectations for coordination, ensuring that commissioning actively supports cross-sector alignment rather than entrenching fragmentation.

If funding remains activity-based rather than outcome-driven, the system will continue to prioritise contract compliance over consumer experience. The question is:

Should governments rethink how they fund mental health services to ensure that money drives real system improvements, not just service activity?



Strengthening national governance and accountability

Governments must shift from passive contract managers to active system stewards, shaping the architecture of mental health care, not just funding its parts. Without a strong national governance framework, fragmentation will deepen, and duplication will continue to arise in contested spaces.

Duplication is not a dominant issue at the acute level, where state governments clearly hold responsibility. But in the community and primary mental health space, duplication is increasingly evident, particularly where Commonwealth-funded PHNs and state-funded services operate with overlapping scope but without shared planning or accountability. This creates confusion for consumers, limits continuity of care, and fuels competition rather than collaboration.

These “jumbled” spaces are now the frontline of mental health reform. While they offer the greatest opportunity for early intervention, prevention, and integrated support, they are also where fragmentation is most visible - in digital infrastructure, service pathways, and commissioning approaches.

The challenge is clear:

Should governments mandate shared accountability and governance to prevent further fragmentation or continue to allow decentralisation to define the future of mental health care?

Possible solutions could include:

- A single national commissioning framework to align PHN-funded services and reduce regional inconsistency in design, triage, and implementation.
- Stronger state mandates for integration, requiring locally funded services to demonstrate cross-sector collaboration and provide clear pathways to and from PHN-commissioned services.
- Governance structures to rationalise digital investment, ensuring tools for navigation, referral, and triage are interoperable and consumer-centred, not competing or duplicative.

If governments do not step into a clearer system stewardship role, the mental health landscape will remain a fragmented ecosystem of disconnected programs.

Creating a truly integrated consumer experience

The burden of system complexity currently falls on the consumer. Instead of expecting individuals to navigate multiple disconnected services, re-tell their stories, and coordinate their own care, the system itself should be designed around ease of access, relational continuity, and early engagement.

In practice, this means designing joined-up systems that recognise how people actually move through mental health care, across services, settings, and life transitions. A consumer-first approach requires both structural reform and investment in navigation infrastructure, so people can get help before crisis, not just after.

Key reforms could include:

- Embedding integration between health and social services into the system architecture, so that supports like housing, employment, education, and disability services are not siloed from mental health care. Coordination should be built in, not left to under-resourced NGOs or the goodwill of individual workers.
- Developing a unified national digital navigation framework, ensuring that referrals, triaging, and service directories are interoperable and consistent across PHNs, states, and service types. This framework should support both consumer-facing tools and clinician-facing infrastructure, reducing duplication and friction.
- Embedding consumer-first design principles into commissioning and funding decisions, so that integration is not optional. Every new initiative should be assessed not just for operational feasibility, but for its impact on consumer experience, continuity of care, and navigation burden.
- Designing models of guided access, such as care coordinators, central intake hubs, or AI-assisted triage systems, to support people in navigating the system early, especially those at risk of falling through the cracks.

The assumption that consumers will independently find their way through a fragmented, duplicative system is no longer tenable. Without early, supported navigation, too many people are left to manage on their own, increasing the risk of disengagement, delayed care, or escalation to more intensive services.

Current reforms: An opportunity to build on what works

The mental health system does not need more services, more contracts, or more funding churn - it needs a deliberate redesign that prioritises integration, consumer outcomes, and long-term sustainability.

The Commonwealth Government is currently progressing a series of reforms aimed at strengthening mental health care across Australia. If well executed, these initiatives represent a genuine opportunity to improve national consistency, reduce fragmentation, and build a more coherent, consumer-centred system. But without attention to the principles and recommendations outlined in this paper, there is a real risk that reforms could add complexity rather than reduce it. Layering new initiatives on top of existing silos, without addressing governance, integration, and accountability, may further confuse help-seekers and dilute provider responsibility.

⁸ Medicare Mental Health. (2025, n.d.). About Us.

⁹ Department of Health, Disability and Ageing. (2024, Dec 20). NEIS Draft Service Model.

¹⁰ SANE. (2025, Mar 21). Digital Navigation Project.



Medicare Mental Health

In February 2025, Head to Health was renamed to Medicare Mental Health, to ensure the branding of face-to-face and digital mental health initiatives is more consistent with other trusted Government health services. In partnership with State Governments, the Commonwealth is looking to establish 61 Medicare Mental Health Centres across Australia by mid-2026. These centres, in conjunction with the website and phone service, will act as the primary national connection point for Australians seeking free, quality mental health support aligned with their needs.⁸

National Early Intervention Service

The Commonwealth Government has announced funding for a new national early intervention service providing evidence-based digital mental health support from 1 January 2026 without the need for a diagnosis or GP referral. Through delivering low intensity cognitive behavioural therapy, the service aims to alleviate pressure on higher acuity services (such as Better Access and hospital systems) through supporting those experiencing mild mental ill health and transient distress before symptoms progress. This service is intended to improve linkages within the broader mental health system through effective intake, assessment and referral processes.⁹

Digital Navigation Project

In 2024-2025, the Commonwealth commissioned a sector-wide investigation into the fragmentation of the mental health system. This project has recommended a series of enhancements to strengthen and better connect the system, to enable more Australians to access timely and appropriate support. These recommendations include a smart system-wide search tool to match consumer needs to services – powered by a standardised directory and integrations that allow services to talk to each other and share relevant data (with appropriate safeguards).¹⁰

The conclusion? Governments must take back system leadership

This report has outlined a set of practical, forward-looking recommendations to support a mental health system that is fair, efficient, and resilient. It highlights where governments must lead, where commissioners must reframe how care is funded, and where government can support smarter, more sustainable system design.

At the heart of the issue lies a critical question:

Will governments continue to allow fragmentation and decentralisation to define the future of mental health care or will they reclaim responsibility for building a system that is integrated, accountable, and designed around the people it serves?

Australia's mental health system currently operates without a true owner of whole-of-system accountability. Responsibility is scattered. Risk is shifted downward, not managed, and commissioning takes place in silos with limited coordination. The assumption that market-driven approaches will naturally produce integration and efficiency has not held true. Instead, it has resulted in duplication, gaps, and avoidable harm.

The system is no longer fit for purpose. Without reform, the burden will continue to fall on frontline services and help-seeking individuals - those least equipped to navigate systemic complexity.

What's needed now is a deliberate pivot: from passive contract management to active system stewardship. Governments must step up, not simply as funders, but as system architects, with a clear mandate to design for coherence, enforce integration, and ensure that all parts of the mental health system work together as a unified whole.

Key questions that demand answers:



Who is ultimately responsible for system coherence? If no single entity owns the system's performance, is it any surprise that it remains fragmented?



Should Commonwealth and State Governments impose stricter mandates on integration? If local flexibility has created inconsistency and inefficiency, do we need clearer national standards to force alignment?



How do we ensure commissioning prevents fragmentation rather than reinforcing it? Are we funding services in a way that drives collaboration, or are we rewarding disconnected, short-term activity?



Can risk-sharing be built into contracts rather than assumed? If risk is an inherent part of service delivery, should accountability be explicitly structured into agreements rather than left to individual providers to manage?

About KPMG's Healthcare practice

KPMG is a global organisation of professional services firms whose consultants provide support to healthcare systems, providers, and insurance organisations. Our multi-disciplinary approach allows us to pull resources from across geographies, disciplines and areas of experience from a network of 5,000 dedicated professionals who are focused on healthcare in more than 70 countries and jurisdictions. This network includes almost 200 clinicians who have a wealth of frontline health and care experience as physicians, nurses, paramedics, psychologists, social workers and other professions.

Global insights, local experience

Approaches that have worked in one jurisdiction can often be applied to others. By collaborating globally, we help ignite transformative change by leveraging:

- A 'global-local' approach that combines knowledge of domestic healthcare systems and their stakeholders with global insights, leading industry practices and subject matter experts, allowing organisations to navigate their unique challenges while staying on top of global trends.
- A suite of market-tested digital health solutions and global alliances with world-leading technology and data companies.
- A dedicated network of healthcare-sector audit, tax and advisory professionals.

We're ready to help

Around the world, governments, insurers and commercial healthcare providers turn to KPMG firms because of our wide breadth and depth of sector knowledge. As a testament to this, many of the case studies found in this publication clearly illustrate the abilities of KPMG professionals to assist healthcare organisations and systems in bridging the gap between challenges and opportunities.

No matter where your healthcare organisation is on its transformation journey, KPMG's healthcare practice can help. Talk to us today to learn how we can make a difference as your organisation addresses today's challenges and future needs. A new world of healthcare awaits.

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