



2026-27

Commonwealth Treasury Pre-Budget Submission

Patient Activation Measure (PAM[®])
National Implementation

Acknowledgement

Client Focused Evaluation Program (CFEP) Surveys is committed to supporting reconciliation among Indigenous, Aboriginal and Torres Strait Islander peoples and non-Indigenous Australian people.

We acknowledge the Aboriginal and Torres Strait Islander peoples as the Traditional Custodians of the lands and waters. We pay respect to Elders – past, present and emerging – and acknowledge the important role Aboriginal and Torres Strait Islander peoples continue to play within our community.

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Executive Summary

1

Australia's health system is under increasing pressure from chronic conditions, population ageing and growing demand on primary and acute care, with a substantial share of expenditure linked to conditions that are potentially preventable ^{[1][2][3]}. While recent reforms emphasise prevention and person-centred care, current models lack consistent, practical tools to understand and respond to people's capability to manage their health, limiting the effectiveness of these reforms ^{[4][5]}.

This submission proposes a nationally scalable approach to embedding patient activation as a core capability within primary care, chronic condition management and prevention. Patient activation, measured using the validated Patient Activation Measure (PAM[®]), captures a person's knowledge, skills and confidence to manage their health. It provides a practical mechanism to tailor care, target support and measure meaningful improvement over time, particularly for people with chronic and complex conditions ^{[4][6]}.

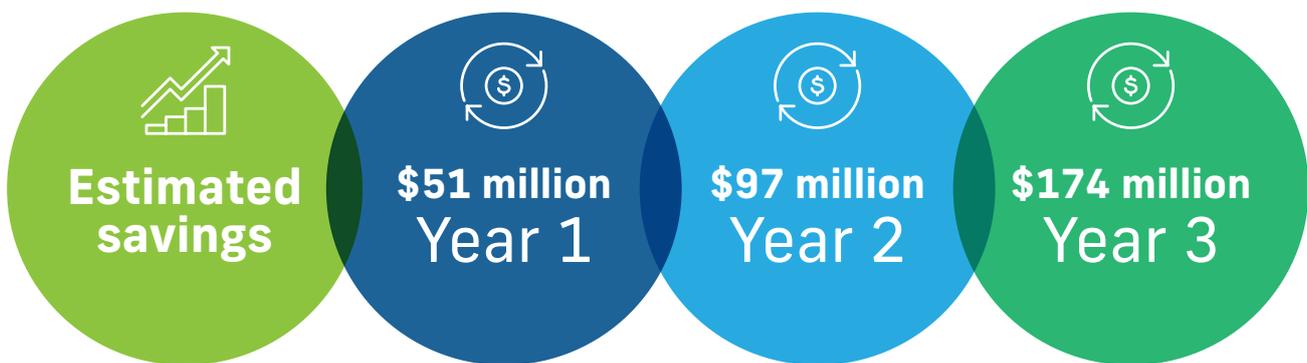
The proposal seeks Commonwealth support to embed patient activation within existing Medicare funded models of care, including general practice, MyMedicare and Chronic Condition Management (CCM) arrangements, Primary Health Network (PHN) commissioned services, Aboriginal Community Controlled Health Organisations (ACCHOs), community health services and other partners. Rather than creating a new program, the approach strengthens the effectiveness of services already funded by government. It directly responds to findings from the PHN Program Final Report, which identified the need for improved outcome measurement, more targeted commissioning and stronger prevention across the PHN and primary care system ^[7].

"This submission proposes a nationally scalable approach to embedding patient activation as a core capability within primary care, chronic condition management and prevention. "



Initial Commonwealth investment of approximately \$1.6 million in Year 1 would support national coordination, workforce capability building, digital integration and reporting evaluation, enabling staged implementation across jurisdictions and service settings. As patient activation improves, evidence indicates a corresponding reduction in avoidable hospital utilisation, supporting better outcomes, improved equity and more effective use of existing health expenditure ^{[8][9][10][11]}.

Based on updated Australian chronic condition prevalence and expenditure ^{[1][2][3]}, a staged national rollout of patient activation delivers substantial and growing savings to the Commonwealth. **Conservative modelling shows that supporting low-activation patients to achieve modest improvements in activation, consistent with international evidence, reduces avoidable hospital admissions and emergency department use, generating estimated savings of \$51 million in Year 1, \$97 million in Year 2 and \$174 million in Year 3 as scale increases.** These savings accrue through more appropriate use of existing Medicare-funded services and reduced reliance on high-cost acute care, strengthening the sustainability and value for money of current health system investment.



Decision sought:

That the Commonwealth support the progressive embedding of patient activation within existing Medicare funded models of care through national implementation, evaluation and integration into ongoing policy and funding frameworks. Implementation and support would be provided through the Australian General Practice Accreditation Limited (AGPAL) Group of Companies, drawing on the patient activation and outcomes measurement expertise of CFEP Surveys.

This proposal has been developed by CFEP Surveys as a suggested implementation model informed by evidence, program experience and current reform directions. It is intended to support discussion and refinement and can be adapted, staged or modified as required to align with Commonwealth priorities, policy settings and funding frameworks. CFEP Surveys welcomes further dialogue with the Commonwealth to shape the approach, implementation design and governance arrangements as appropriate.

Background

(Organisation Context)

2.1 The AGPAL Group of Companies

The AGPAL Group of Companies (AGPAL Group) supports health, community and human services organisations through accreditation, feedback and education services focused on quality and continuous improvement. The Group includes Australian General Practice Accreditation Limited (AGPAL), Quality Innovation Performance Limited (QIP), CFEP Surveys and Care Opinion Australia, working collectively to strengthen care quality, consumer experience and improvement capability across diverse care settings.

The AGPAL Group has a national footprint and experience working with governments, PHNs and service providers to support the design and implementation of quality and safety systems across primary care and community health services.

2.2 CFEP Surveys within the AGPAL Group

CFEP Surveys is the AGPAL Group entity specialising in healthcare feedback and outcomes measurement. Since 1995, CFEP Surveys has supported healthcare professionals and organisations to use structured patient and colleague feedback to inform service improvement.

CFEP Surveys' work spans survey design, administration, data analysis and reporting, with a particular focus on supporting services to interpret results and translate findings into practical, evidence-informed improvement activity. This includes building capability to use feedback and outcomes of data as part of routine service design, commissioning, and decision-making.

As part of this capability, CFEP Surveys holds the exclusive Australian licence for the Patient Activation Measure® (PAM®). PAM® measures a person's, knowledge, skills and confidence to manage their health and is used to support population insight, tailoring of care and measurement of change over time, and is implemented in a way that integrates with existing service workflows and data systems.

Since 1995, CFEP Surveys has supported healthcare professionals and organisations to use structured patient and colleague feedback to inform service improvement.

2.3 Experience working with PHNs and service partners

CFEP Surveys has experience working with PHNs and other service partners where patient experience and patient activation data inform commissioning, performance reporting and quality improvement. This work is underpinned by a strong evidence base demonstrating that patient activation is a meaningful predictor of health behaviours, service use and outcomes ^{[9][10]}.

International evidence shows that higher activation is associated with greater engagement in preventive care, better adherence to treatment and fewer avoidable hospitalisations, while lower activation is associated with higher use of unplanned and higher-cost care ^{[8][9][10][11]}. Integrating patient experience and activation data supports more targeted commissioning and clearer assessment of whether services are strengthening patient capability and outcomes over time ^[12].

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Measure® (PAM®).



The Problem

Australia's health system is facing increasing pressure from rising rates of chronic conditions, population ageing, persistent health inequities and growing demand on primary and acute care services ^{[1][2]}. Chronic conditions account for a substantial share of health system activity and expenditure and are a major driver of pressure on Medicare, hospitals and the health workforce.

A significant proportion of this burden is associated with potentially preventable complications of chronic conditions, including avoidable hospital admissions and emergency department presentations ^{[2][3][6][10]}. These patterns contribute to rising costs and sustained pressure on already constrained services, particularly in primary care and hospital outpatient settings.

Australia's chronic condition burden and need for better prevention and coordinated responses is a focus of the National Strategic Framework for Chronic Conditions, which provides high-level guidance for a coordinated national response to prevention and management of chronic conditions ^[11].

Current models of care, however, do not consistently assess or respond to a person's readiness or capability to self-manage their health. Care is often delivered without sufficient differentiation between individuals who require intensive support and those who could be managed through lighter-touch approaches, leading to variable outcomes and inefficient use of clinical and system resources ^{[12][13]}. There is limited systematic use of measures that capture a person's knowledge, skills and confidence to manage their health. Without this information, clinicians and commissioners lack visibility of where support is most needed, how to tailor care effectively, or whether funded services are strengthening patient capability over time ^{[4][13][14][15]}.

Evidence consistently demonstrates that lower patient activation is associated with higher hospital use, emergency department attendance and healthcare costs, while higher activation is linked to better self-management, more appropriate service use and improved outcomes ^{[6][8][9][10][12]}. Despite this, activation and self-management capability are not routinely measured or embedded within care delivery, commissioning or funding frameworks.

This gap has been explicitly recognised in the Review of General Practice Incentives^[16], which identified the need for foundational infrastructure and capacity-building support to enable practices to implement structured measures such as Patient Reported Experience Measures, Patient Reported Outcome Measures and the PAM[®]. The review highlights that without investment in appropriate software, data capability and workforce training, practices are limited in their ability to use patient-reported information to support continuous quality improvement and person-centred care. In defining patient activation as the process through which providers support people to take an active role in their health and care, the review reinforces that self-management capability is a system issue rather than an individual deficit.

Primary care reforms and the PHN Program Final Report emphasise prevention, continuity and person-centred care, including improved management of chronic conditions. However, in the absence of consistent tools to assess patient capability, the effectiveness of these reforms is constrained. Without reliable insight into readiness to self-manage, it remains difficult to align care models, commissioning decisions and workforce effort with individual need ^[7].

If current approaches remain unchanged, the health system is likely to continue investing significant resources in managing preventable complications rather than strengthening people's capacity to manage their health earlier and more effectively. Demand for primary care and hospital services is expected to continue rising in line with growing chronic condition prevalence, with a substantial proportion of this demand remaining avoidable ^[17]. This trajectory risks compounding pressure on the health workforce, escalating costs and widening inequities for populations facing greater barriers to managing their health ^[2].

The Mitchell Institute's Self Care for Health: A National Policy Blueprint highlights that effective self care, including the knowledge, skills and confidence required to manage health and long term conditions, depends on supportive policy settings and health system design. The blueprint calls for system level approaches that embed self care support within health services, commissioning and policy frameworks, rather than relying solely on individual behaviour change ^[18].

Policy commentary aligned with the Royal Australian College of General Practitioners' work on self care similarly emphasises the importance of enabling people to play an active role in managing their health and preventing disease, and recognises the need for system wide reforms to better support self management and person centred care ^[19].

Taken together, government-commissioned reviews and national policy frameworks, including the PHN Program Final Report, Primary Health Care 10 Year Plan, National Chronic Condition Framework, Strengthening Medicare Taskforce Report and Review of General Practice Incentives, consistently point to the need for more preventive, outcome focused and sustainable models of care. These reviews identify a shared gap in current arrangements: the absence of a consistent, scalable way to assess and respond to patient capability. This context underscores the need for practical tools that can operationalise reform intent within existing care models, setting the foundation for the proposed approach outlined in the following section ^{[5][7][20][21]},

If current approaches remain unchanged, the health system is likely to continue investing significant resources in managing preventable complications rather than strengthening people's capacity to manage their health earlier and more effectively.



The Proposed Solution

Patient activation provides this missing mechanism by offering a validated, system-ready way to assess and respond to people's capability to manage their health, strengthening prevention, CCM and value for money within existing Medicare funded care.

4.1 Embed PAM[®] into funding and incentives

This submission proposes embedding patient activation as a core capability within existing primary care, CCM and prevention settings. Patient activation refers to a person's knowledge, skills and confidence to manage their health and health care and is measured using the validated PAM[®] [6][9][13],

Embedding patient activation provides a practical way to differentiate care according to individual capability, enabling clinicians and services to tailor education, support and follow up. This supports more effective use of existing services and aligns with the objectives of person-centred and preventive care [16][21]. This would include amendments to the CCM items and associated Medicare Benefits Schedule (MBS) criteria to require that: [22][23]

- Each patient registered with MyMedicare completes a baseline Patient Activation Measure, with reassessment every 4–6 months thereafter.
- MBS funding for CCM items is increased proportionately to account for the additional time required to undertake these activities.

4.2 Strengthening the effectiveness of existing models of care

Rather than creating a new program, the proposed approach integrates patient activation within existing Medicare-funded models of care, including general practice, MyMedicare and CCM arrangements [22][23]. Activation data supports shared decision-making, more appropriate care planning, and clearer identification of people who may benefit from additional support.

At a system level, patient activation data provides commissioners with improved visibility of need, outcomes and variation across populations, supporting more targeted commissioning and performance monitoring [7].

4.3 National implementation and scalability

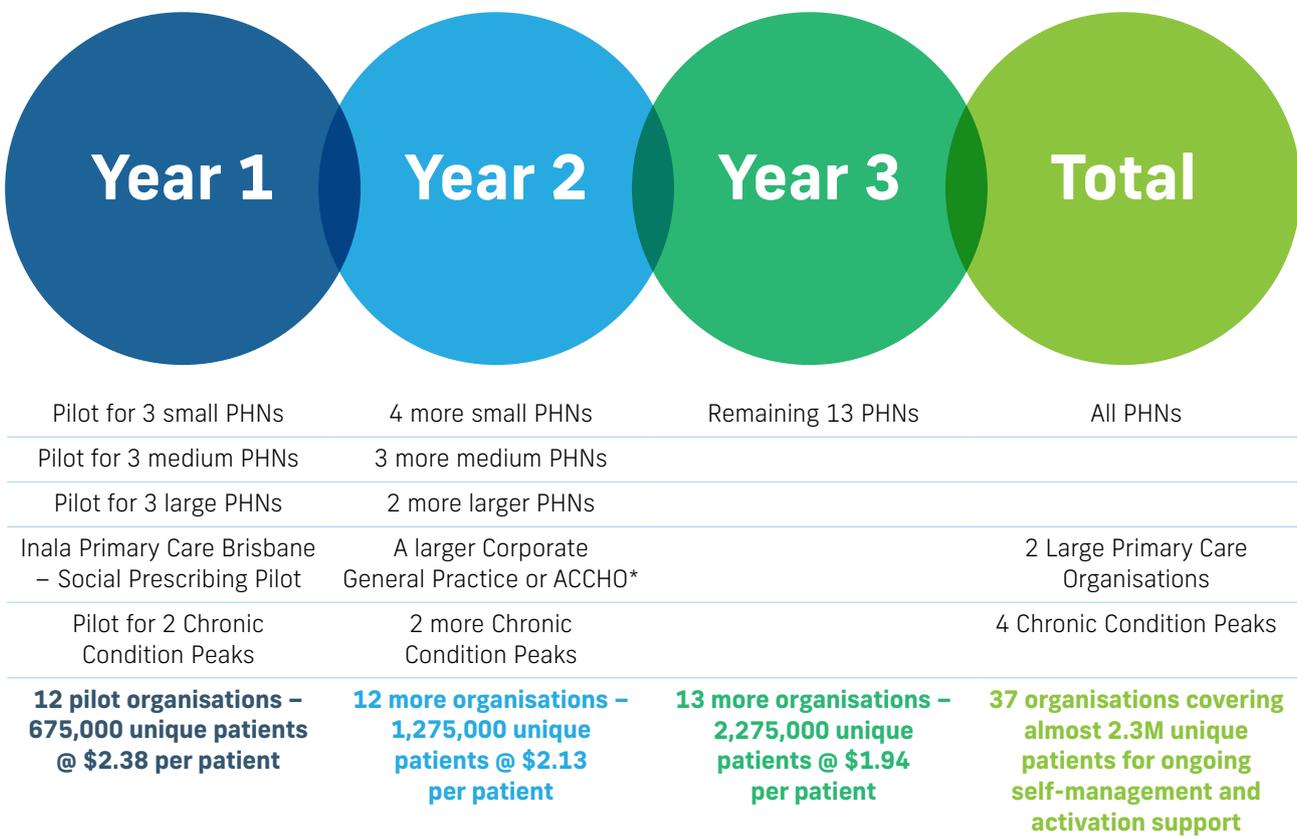
The proposed investment supports a staged, learning-based rollout over three years, progressively expanding coverage while building system capability and evidence.

Year 1 focuses on piloting implementation across a representative mix of small, medium and large PHNs, selected primary care and chronic condition peak organisations. This phase establishes governance, digital integration, workforce capability and baseline PAM® across approximately 675,000 patients, enabling early learning and refinement.

In Year 2, implementation expands to additional PHNs, primary care organisations and chronic condition peaks, increasing coverage to approximately 1.3 million patients. This phase consolidates operational capability, embeds activation-informed workflows, and begins to demonstrate measurable improvements in activation and early indicators of service use, while supporting more targeted commissioning and care delivery.

Year 3 completes the national rollout across all PHNs and participating organisations, reaching approximately 2.3 million patients. This phase focuses on consolidation, sustained use of activation data in care and commissioning, and comprehensive evaluation. By the end of the three years, patient activation is established as a routine, scalable capability supporting self-management, prevention and chronic condition care, with evidence to inform longer-term integration into Commonwealth funding and policy frameworks.

Table 1 - Implementation and rollout plan



Year 1	Year 2	Year 3	Total
Pilot for 3 small PHNs	4 more small PHNs	Remaining 13 PHNs	All PHNs
Pilot for 3 medium PHNs	3 more medium PHNs		
Pilot for 3 large PHNs	2 more larger PHNs		
Inala Primary Care Brisbane – Social Prescribing Pilot	A larger Corporate General Practice or ACCHO*		2 Large Primary Care Organisations
Pilot for 2 Chronic Condition Peaks	2 more Chronic Condition Peaks		4 Chronic Condition Peaks
12 pilot organisations – 675,000 unique patients @ \$2.38 per patient	12 more organisations – 1,275,000 unique patients @ \$2.13 per patient	13 more organisations – 2,275,000 unique patients @ \$1.94 per patient	37 organisations covering almost 2.3M unique patients for ongoing self-management and activation support

*Although potentially covered by the PHN PAM program, this will add another dimension to the pilot to show PAMs effectiveness across varying programs and models.

Implementation would be supported through national coordination, workforce capability building, and digital integration with existing clinical and commissioning systems, minimising additional reporting burden.

Implementation would be piloted through PHNs and associated practices included in the of the proposed PAM implementation program.

These changes would enable the PAM® to be embedded within existing workloads, supporting seamless integration with current programs and funding mechanisms.

4.4 Supporting sustainability and value over time

As patient activation improves, evidence indicates a corresponding reduction in avoidable hospital utilisation, supporting a sustainable, value-based approach in which patient activation is maintained through ongoing, proportionate investment alongside Medicare funded care ^{[9][10][12][18][19]},

Embedding patient activation as a routine capability strengthens the impact of existing reforms, supports more efficient use of resources, and provides government with a practical mechanism to improve outcomes and system sustainability over time ^{[7][16][17][20][21]}.

Commonwealth support would enable four core outcomes:

- Establishment of patient activation as a nationally consistent measure to inform care planning, commissioning and performance monitoring.
- Workforce capability to use activation data to tailor care and target support, strengthening effectiveness without adding reporting burden.
- Digital integration and coordination to enable secure, consistent data flow, aggregation and evaluation across settings and jurisdictions.
- Independent evaluation (if required) to build the Australian evidence base required to inform future policy and funding decisions.

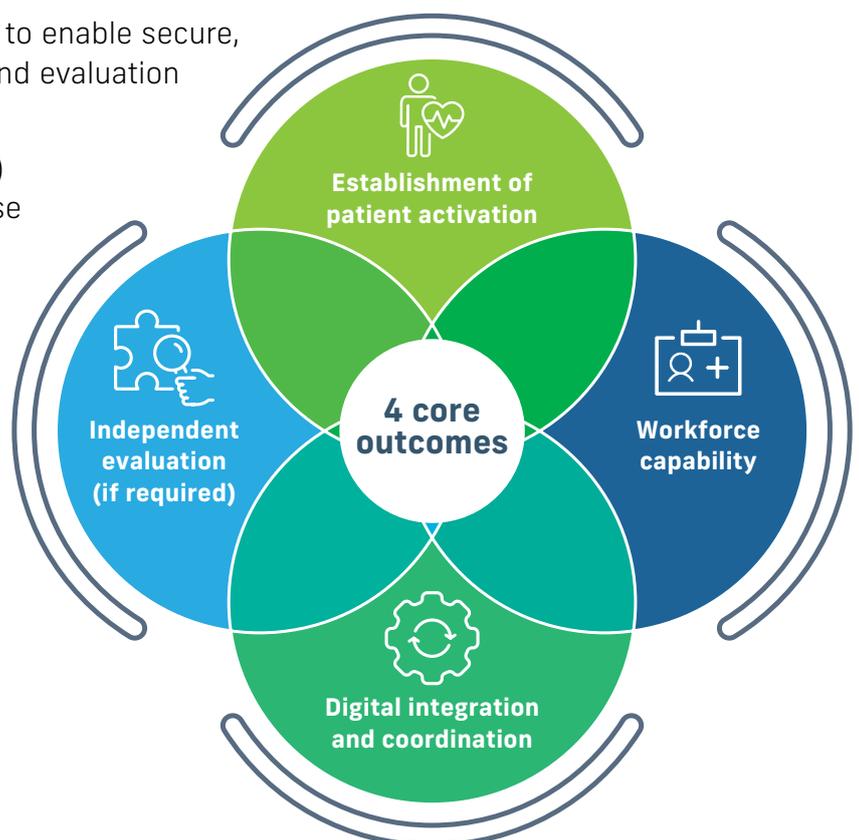


Figure 1 - Four core outcomes

Objectives & Outcomes

(What success looks like)

The proposed investment is focused on improving outcomes from existing Commonwealth investment in primary care, CCM and prevention. It supports national priorities for person-centred, preventive and value-based care by strengthening how services respond to patient capability rather than increasing service volume.

5.1 Objectives

The objectives of this proposal are to:



1. Improve the effectiveness of Medicare-funded care

Support clinicians to better target MBS-funded services by aligning care with a patient's capability to self-manage, improving appropriateness, continuity and outcomes ^{[12][13]}.



2. Strengthen MyMedicare and CCM delivery

Embed a consistent, validated measure of patient capability within MyMedicare and CCM arrangements to support proactive, tailored care for people with ongoing and complex needs ^{[13][14]}.



3. Reduce avoidable utilisation among high-need cohorts

Improve identification and management of low-activation, high-utilisation cohorts, including frequent hospital users, to reduce potentially preventable hospital admissions and emergency department presentations ^{[15][16]}.



4. Improve patient capability and equity of outcomes

Increase the knowledge, skills and confidence of people living with chronic conditions to manage their health, with particular benefit for populations facing greater barriers to self-management ^{[9][14][15]}.

Activation-informed workflows, including tailored communication and referral processes, support improved attendance, continuity and outcomes.



5. Build Australian evidence for future decisions

Generate robust Australian evidence on effectiveness, scalability and return on investment to inform future Commonwealth policy and funding settings ^[23].

5.2 Expected outcomes

Success over the medium term (2–3 years) will be demonstrated through:

- More person-centred primary care, with routine use of activation data to inform care planning and CCM activities ^{[12][13]},
- Improved outcomes for MyMedicare and chronic condition cohorts, reflected in measurable improvements in patient activation scores ^{[14][23]},
- Reduced avoidable utilisation among frequent users, consistent with Australian and international evidence linking improved activation with lower hospital and emergency department use ^{[9][10][13][23]},
- Demonstrated value for money, with modelling indicating that even modest improvements in activation among low-activation patients can deliver substantial system savings, including an estimated \$456 million per year from a one-point activation increase across this cohort ^[24],
- Stronger commissioning and accountability, through use of activation data to support PHN commissioning, monitoring and evaluation ^{[7][14]},

5.3 Alignment with Commonwealth priorities

The objectives and outcomes directly support Commonwealth priorities by strengthening the effectiveness of existing Medicare funded activity, including the Medicare Benefits Schedule, MyMedicare and CCM arrangements. The proposal aligns with the Strengthening Medicare Taskforce Report and the Primary Health Care 10 Year Plan by supporting more person centred, preventive and multidisciplinary care, informed by better use of data and outcome measurement. It also responds to the Review of General Practice Incentives, which identified the need for foundational infrastructure and capability to support the use of patient reported measures, including patient activation, to inform quality improvement and funding reform. Together, these reforms are supported by improved targeting of care for high-need cohorts, including frequent hospital users, and by advancing value-based healthcare through measurable outcomes, equity improvements and demonstrated return on investment ^{[9][10][16][20][21][22][23]},



Who benefits – target groups and cohorts

The proposed approach is designed to deliver benefits at multiple levels of the health system, with a particular focus on people and services where improved patient activation is most likely to deliver meaningful gains in outcomes, equity and value for money.

Patient activation is particularly important given that the majority of factors influencing health outcomes occur outside the clinical setting. Evidence indicates that social, behavioural and environmental determinants account for a far greater share of health outcomes than healthcare alone, underscoring the importance of strengthening people's capability to manage their health beyond clinical encounters ^[25].

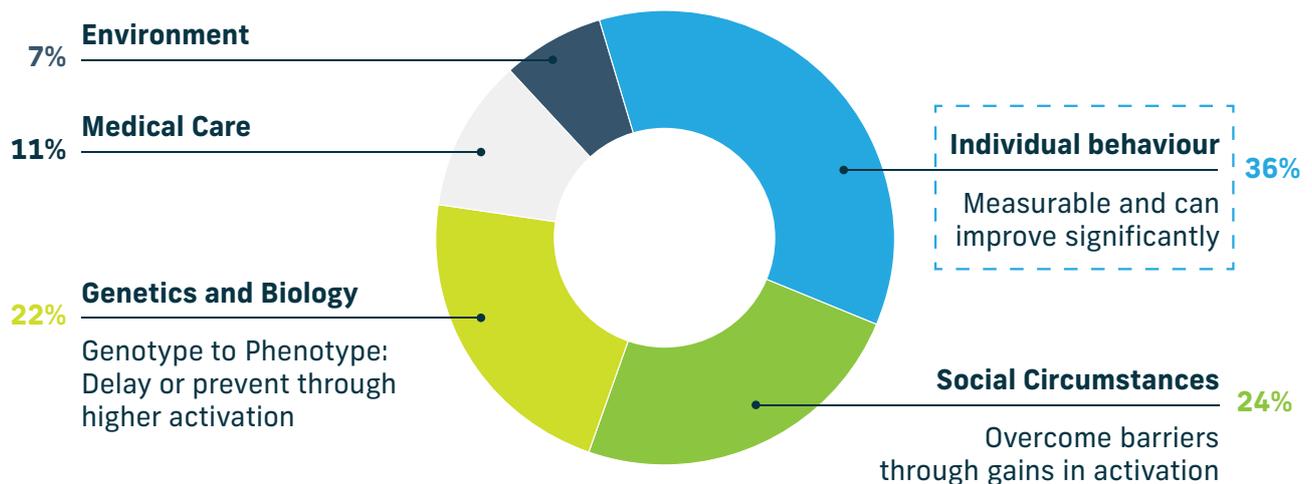


Figure 2 - Factors that influence health outcomes



6.1 Priority patient cohorts

The primary beneficiaries are people living with chronic and complex conditions, particularly those with lower capability to manage their health and health care. Evidence indicates that individuals with lower levels of patient activation experience poorer outcomes, lower engagement with preventive care and higher use of unplanned and high-cost services ^{[9][17][23]},

Priority cohorts include:

- People living with one or more chronic conditions (namely Diabetes, Cardiac Disease, Arthritis, Cancer and others), particularly those with multimorbidity ^[2]
- Individuals who are frequent users of hospital and emergency department services
- First Nations peoples, who experience higher rates of chronic condition and avoidable hospitalisation ^[26]
- People living in rural and remote communities, where access barriers increase the importance of effective self-management ^[27]
- People from culturally and linguistically diverse communities, who may face additional barriers to navigating the health system and engaging with care ^[28]

Embedding patient activation enables services to better identify people with greater needs, tailor support appropriately and monitor improvement over time, supporting more equitable outcomes across these cohorts. Engaging chronic conditions peak organisations through the carefully planned implementation will assist with engaging these vulnerable groups.



6.2 Benefits for practices and service providers

General practices, ACCHOs, community health services and other commissioned providers benefit through improved visibility of patient need and capability. Patient activation data supports more effective care planning, differentiation of care intensity and targeted use of education and support resources ^{[9][10][12][13]}.

This approach also supports workforce sustainability by helping clinicians focus time and effort where it is most needed, reducing inefficiencies associated with one-size-fits-all models of care ^[23].

Activation data can also provide valuable context for understanding variation in consultation length and service intensity, including the legitimate need for longer consultations where patients have lower capability to self-manage. This information supports more nuanced Medicare compliance and audit processes, assists practices to monitor and reflect on their own billing profiles, and provides an evidence base for considering additional or adjusted funding for practices serving populations with a high proportion of low-activation patients, where throughput may be lower but clinical effort and complexity are higher ^[23].

Embedding patient activation within routine care also supports clinician wellbeing and workforce sustainability. By making patient capability visible, clinicians are better equipped to understand why some patients struggle to follow advice or engage with care, and to adjust their approach accordingly. This reduces frustration associated with perceived non-adherence and provides a clear clinical rationale for spending additional time, using different communication strategies or referring to alternative supports where appropriate. Over time, this supports more realistic expectations, more effective consultations and improved professional satisfaction, contributing to reduced burnout in primary care teams managing increasing complexity and demand.

6.3 Benefits for commissioners and the health system

PHNs and other commissioners benefit through improved population insight, enabling more targeted commissioning, clearer performance monitoring and stronger assessment of whether funded services are improving patient capability and outcomes as identified in the recent PHN Program final report ^[7].

At a system level, the Commonwealth benefits through improved value for money, reduced avoidable demand on hospitals and better alignment between policy intent and service delivery. Over time, improved patient activation supports a shift toward prevention, earlier intervention and reduced reliance on high-cost, reactive care ^{[9][10][16]}.

Strengthening patient activation aligns with broader evidence on the determinants of health, which shows that healthcare services account for only a small proportion of overall health outcomes^[25]. Improving people's knowledge, skills and confidence to manage their health complements clinical care and supports more sustainable system performance over time ^[24].

Implementation, governance and delivery

The proposed approach is designed to be practical, scalable and low risk, building on existing primary care structures, commissioning arrangements and digital systems. Clear roles across governance, commissioning, service delivery and data enablement support accountability while minimising implementation burden and duplication.

7.1 Governance and oversight

National oversight will be provided through an advisory group facilitated by CFEP Surveys. The group will support strategic direction, alignment with Commonwealth priorities and consistent use of validated measures, while allowing flexibility for local implementation. This approach supports accountability and shared learning without establishing new governance structures.

Membership for the advisory group will include CFEP Surveys management, participating organisations, evaluation partners (if required) and other relevant identified members. Terms of reference will determine scope, frequency and meeting agendas.

7.2 PHNs and chronic condition peak organisations

PHNs will play a central role as implementation partners, supporting commissioning, engagement with practices and service providers, and use of patient activation data to inform local planning and performance monitoring.

Relevant chronic condition peak bodies, consumer organisations and community health partners may be engaged to support alignment with existing disease-specific initiatives, prevention strategies and priority population needs. This enables coordinated delivery while avoiding duplication and fragmentation.

At a system level, visibility of patient activation across services also supports more targeted commissioning, funding and oversight. Where practices and PHNs can identify cohorts with lower activation, commissioning can be better aligned to need, consistent with the findings of the PHN Program Review ^[7].

7.3 Practice and service delivery settings

General practices, ACCHOs, community health services and other participating providers will integrate PAM® into existing workflows. Activation data will be used to inform care planning, tailor support and monitor changes in patient capability over time, with a focus on practical use and tailoring care to enable improved patient self-management practices.

To maximise impact, patient activation information needs to be embedded within routine clinical systems and workflows. Recording a baseline PAM® score as part of CCM and incorporating it into the patient record enables clinicians to tailor care and follow-up based on capability. Making activation level visible within practice software and referral correspondence supports safer, more effective transitions of care by signalling when additional support may be required. For example, patients with low activation may be less likely to respond to automated reminders or navigate appointment processes without assistance. Using activation data to guide communication methods, such as proactive phone contact rather than SMS reminders, can reduce missed appointments, avoid unnecessary re-referrals and improve patient experience while reducing administrative burden across the system.

Training clinicians as part of this implementation, to interpret and apply PAM® scores is critical to realising the benefits of patient activation in practice. Understanding a patient's activation level enables clinicians to tailor the intensity, timing and type of support to match activation levels, rather than applying uniform approaches that may be ineffective or inefficient. This supports more person centred care, improves engagement and self management, and helps clinicians use time and resources more appropriately, particularly when working with people living with chronic and complex conditions.

7.4 Workforce capability and support

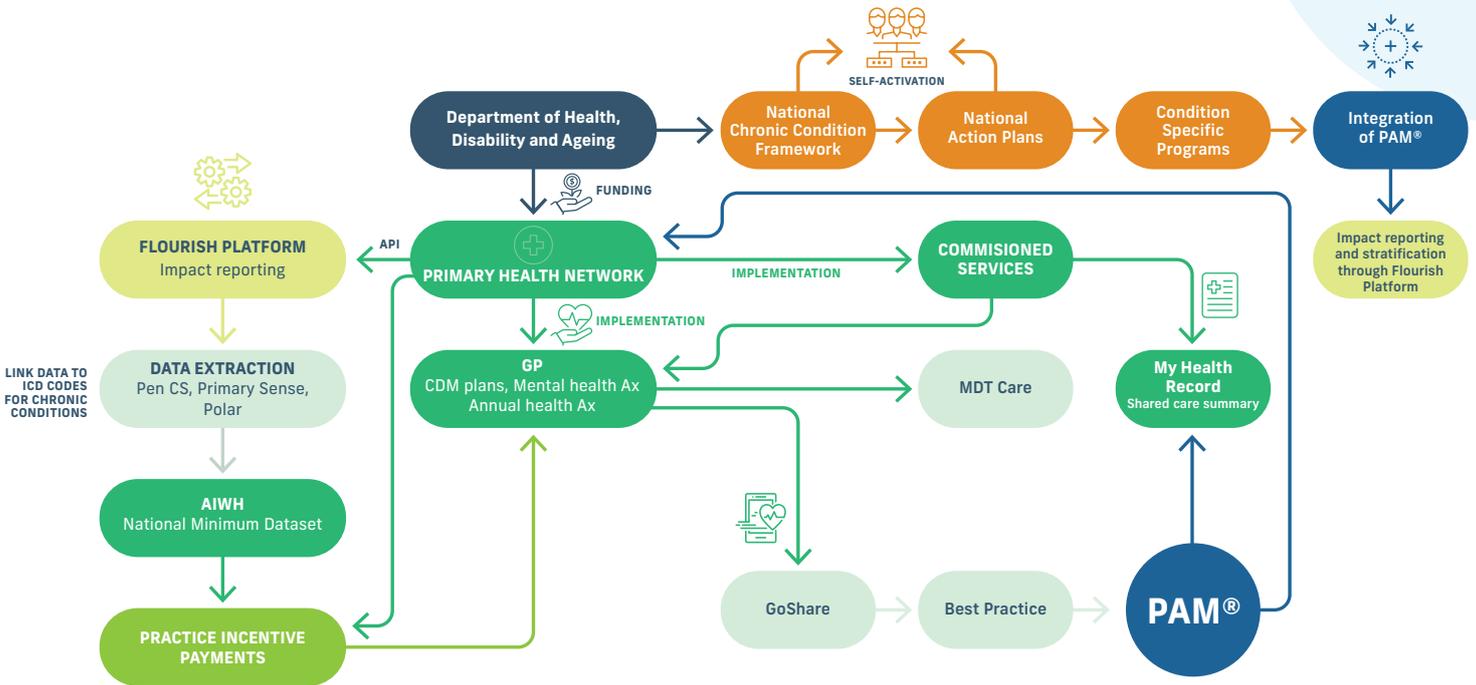
Workforce support will focus on building confidence in interpreting and applying activation data in routine care. Training will be proportionate, role-appropriate and integrated into existing professional development pathways, supporting uptake while minimising burden.

7.5 Digital integration and data flow

Digital enablement will leverage existing clinical, PHN and national digital health systems to support efficient data capture, aggregation and reporting. Integrating with existing practice software and systems including My Health Record ^[29] is a critical element for PAM®. This will enable seamless practice workflows for clinical staff implementing PAM®.

The implementation flow illustrates how patient activation is embedded across four national levers working together: policy, commissioning, incentives and workforce capability, underpinned by digital integration. At a national level, patient activation is aligned with Commonwealth policy settings, including the National Chronic Condition Framework, national action plans and condition-specific programs, establishing a consistent expectation for activation-informed care. Funding and commissioning flow through PHNs, where PAM® can be embedded within contracted chronic condition, mental health, prevention and social prescribing services to support consistent measurement and program design.

Figure 3 - Implementation Flow Chart



At the practice and service delivery level, activation data is used by clinicians to tailor CCM plans, mental health assessments, annual health checks and multidisciplinary care, supported by workforce capability building and clinical decision-support tools. Digital integration enables PAM® data to be captured within practice software and shared care environments, including My Health Record, supporting safer transitions and coordinated care. De-identified activation data is aggregated through established reporting platforms to support PHN commissioning, national evaluation and population planning, including contribution to national datasets. Together, this integrated flow ensures patient activation is not implemented as a standalone tool, but as a system-wide capability embedded within existing funding, clinical and digital infrastructure.

7.6 Staged implementation and risk management

Implementation will be phased to support learning and adaptation, with embedded evaluation informing continuous improvement. Key risks, including variable uptake, workforce readiness and data integration challenges, will be mitigated through staged rollout, use of validated tools and ongoing monitoring. This approach balances national consistency with local flexibility.

This approach will be supported by the below year by year budget.

Budget and use of funds (year-by-year)

The proposed investment is structured as a three-year initiative, designed to support staged implementation, evaluation and decision-making. Funding is focused on enabling delivery through existing structures rather than establishing new programs or service systems.

8.1 Overview of what funding supports:

- Introduction of PAM® into existing workflows, practices, and care plans (CCM and MBS)
- National coordination and governance
- PHN-led commissioning and support including risk stratification
- Recruitment and implementation support for all involved organisations
- Workforce training, support and webinar delivery
- Digital integration and data enablement
- Independent evaluation (if required) and reporting to measure impact based on activation levels

The approach ensures that outputs are delivered each year, while outcomes build progressively as implementation matures.

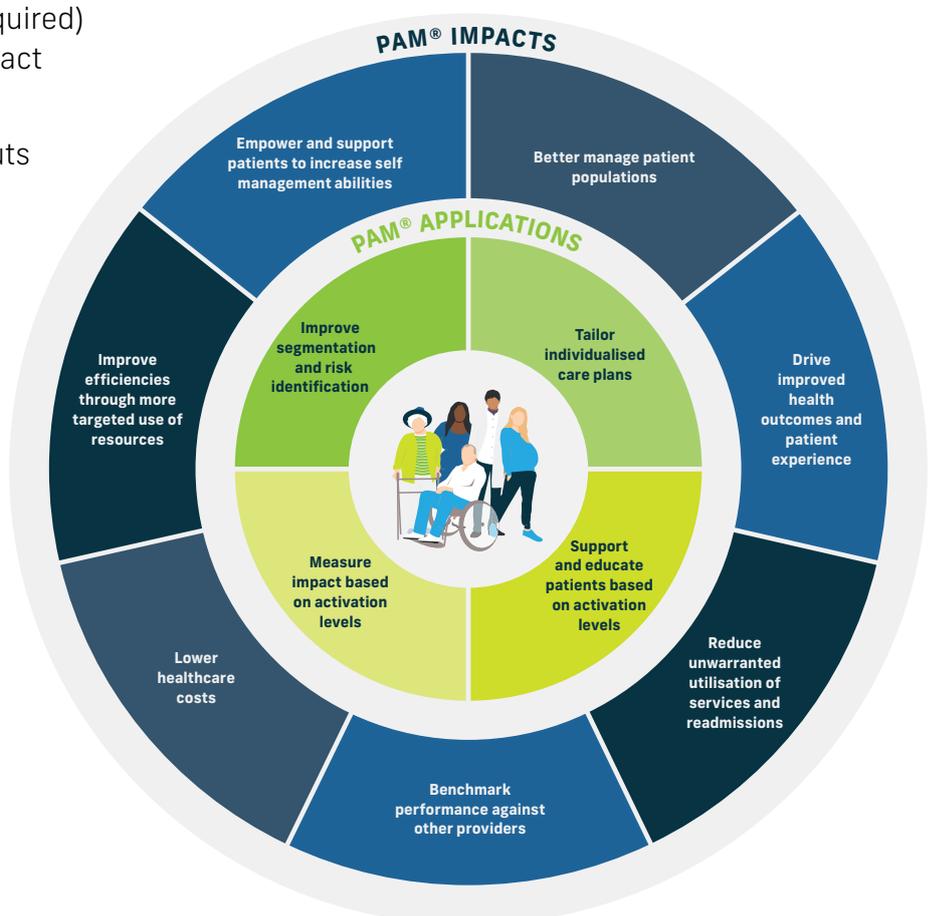


Figure 4: PAM® Impacts

8.2 Indicative year-by-year funding and outputs

Year 1

Establish and pilot
(\$1.6 million;
~\$2.38 per patient)

- Establish national governance, implementation and evaluation frameworks.
- Commence delivery with early-adopter PHNs, community health services and chronic condition partners.
- Deliver initial workforce training, digital integration and baseline PAM®.

Year 2

Expand and refine
(\$2.7 million;
~\$2.13 per patient)
– accumulative
from year 1

- Continue licences and implementation support for participating organisations.
- Expand delivery to additional regions and priority cohorts.
- Undertake interim evaluation and refine implementation based on early findings.
- Strengthen use of activation data to inform commissioning and service planning.

Year 3

Consolidate and
assess impact
(\$4.4 million;
~\$1.94 per patient)
– accumulative
from year 2

- Consolidate implementation across participating regions and services and expand to final cohorts and organisations.
- Complete outcomes reporting and cost-impact assessment.
- Provide advice to government on future integration, scale-up or transition to business-as-usual arrangements.

Together, this staged approach provides the Commonwealth with a low-risk, scalable investment that delivers early learning and measurable outcomes while establishing a sustainable pathway to embed patient activation within routine care and commissioning over time.

Return on investment (ROI) and value for money

With approximately 15.4 million Australians living with one of more chronic conditions and with chronic conditions accounting for more than half of total disease spending, even modest, targeted improvements in patient activation represent a highly cost-effective opportunity to reduce avoidable hospital use and moderate future growth in health system expenditure ^{[1][2][26][27]}. A substantial proportion of chronic condition costs are driven by potentially preventable complications and unplanned care, particularly among people with lower capability to self-manage.

In practical terms, improvements in patient activation are best understood as movement between activation levels. For example, progression from PAM[®] Level 1 to Level 2 reflects a meaningful shift from disengagement and low confidence toward emerging capability for self-management. Evidence consistently shows that patients at Level 1 experience the highest rates of unplanned care and healthcare costs, while even modest improvement is associated with better engagement, improved self-management behaviours and reduced reliance on avoidable hospital and emergency services ^{[4][8][9][10][15][30]}.

9.1 Cost–impact logic

International and Australian evidence consistently demonstrates that people with lower activation, estimated to represent around 40 per cent of the chronic condition population, have higher rates of emergency department use, hospital admissions and overall healthcare costs. In contrast, higher activation is associated with greater use of preventive care, earlier management of exacerbations and more appropriate use of services ^{[9][10][12][13][30][31][32]}.

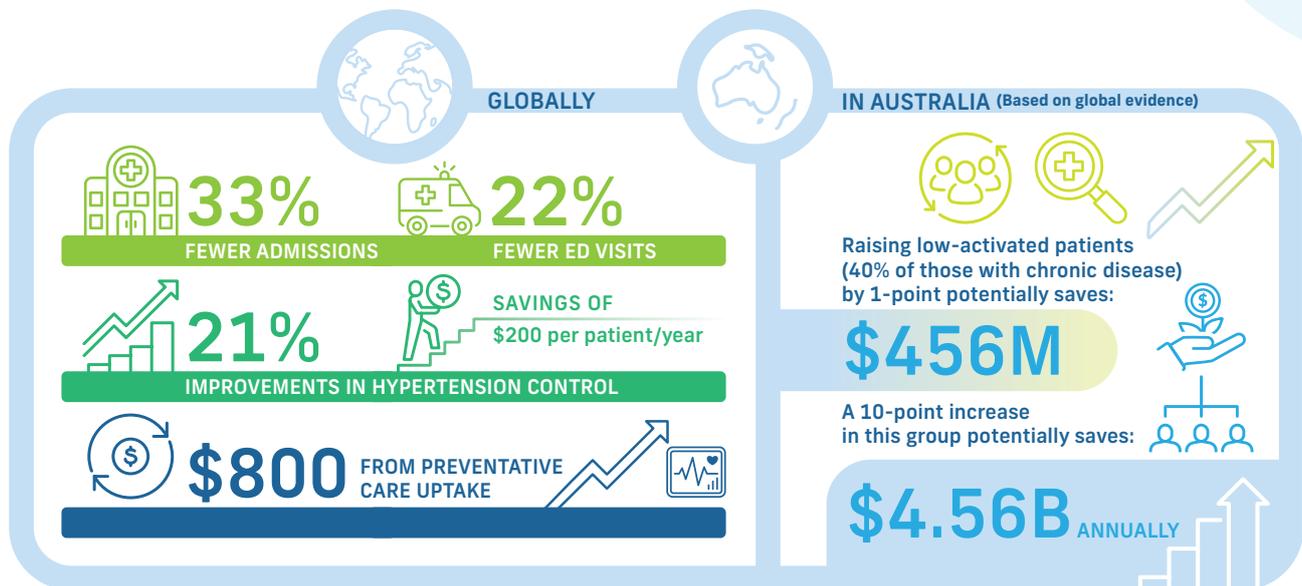
International evidence shows that improvements in patient activation are associated with:

- up to 33 per cent fewer hospital admissions,
- 22 per cent fewer emergency department visits, and
- around 21 per cent lower healthcare costs, equating to approximately \$1,000 per patient per year, alongside improvements in clinical indicators such as blood pressure control and preventive care uptake ^{[30][31][33][34]}
- 1-point improvement in a PAM[®] score shows 3% increase in health outcomes and 3% decrease in healthcare costs ^{[30][31]}.

By identifying people with lower capability to self-manage and tailoring care and support accordingly, patient activation enables more efficient use of existing services, shifting care upstream and reducing avoidable demand on hospitals and emergency departments. ^{[9][10][12][13]},

Figure 5 - Return on Investment for PAM®

Underscores its value in creating sustainable, equitable, and cost-effective healthcare systems



9.2 Australian evidence and system-level implications

Australian studies and modelling indicate that improvements in patient activation are achievable through routine care models and are associated with improved self-management behaviours and reduced use of high-cost services ^[14]. At a system level, even small improvements in activation among low-activation cohorts have the potential to generate substantial savings by reducing avoidable hospital admissions and emergency department presentations, particularly for people with chronic and complex conditions and frequent hospital users ^{[20][30][31]}.

9.3 Value for money for the Commonwealth

Patient activation represents a proportionate, high-leverage investment that strengthens the effectiveness of existing Medicare-funded services rather than creating new programs. By embedding activation as a routine capability within primary care, chronic condition management and prevention, the Commonwealth can improve outcomes and equity while moderating future growth in demand for high-cost acute care ^{[9][10][12][13][30][31]}. Over time, these efficiency gains are expected to offset the cost of ongoing investment, supporting a sustainable, value-based funding approach aligned with Commonwealth reform priorities ^{[24][32][33][34]}.

9.4 Quantifying year-on-year potential savings from improved patient activation

This section quantifies the estimated year-on-year savings to the Commonwealth associated with improved patient activation as the program scales nationally, demonstrating that a relatively modest investment in PAM® over the three-year implementation period is more than offset by reductions in avoidable health service utilisation.

Using updated national chronic condition prevalence and expenditure data, this staged national rollout of patient activation delivers clear and increasing fiscal savings to the Commonwealth over time. Approximately 15.4 million Australians live with chronic conditions, with annual health system expenditure of around \$98 billion, equating to an average cost of \$6,364 per person per year. International and Australian evidence demonstrates that people at low activation levels (PAM Level 1) experience significantly higher rates of potentially preventable hospital admissions, emergency department presentations and unplanned care, and account for a disproportionate share of avoidable health system costs. Research consistently shows that around 40 per cent of people receiving structured activation support can easily achieve at least a one-point improvement in PAM score (usually >7 points can be seen over the first 4 months), which is associated with an average 3 per cent reduction in healthcare utilisation and costs, driven primarily by reductions in avoidable acute care.

Applying this conservative assumption, activation support for 675,000 people in Year 1 is estimated to deliver annual savings of approximately \$51 million, reflecting reduced hospital and emergency department use among around 270,000 low-activation patients. As the program scales, supporting 1.275 million people in Year 2 generates estimated savings of \$97 million per year, and 2.275 million people in Year 3 delivers savings of approximately \$174 million per year. These savings accrue through lower rates of avoidable admissions, reduced emergency presentations and more appropriate use of primary care services, while strengthening existing Medicare-funded activity rather than expanding service volume. Importantly, the benefits compound over time, creating a sustainable, value-based funding model in which modest upfront investment in patient activation yields growing returns and moderates long-term growth in high-cost health service utilisation.



675,000 people

YEAR 1



1.275 million

YEAR 2



2.275 million

YEAR 3

Reporting, independent evaluation and accountability

Evaluation and accountability are central to the proposed investment, ensuring that implementation is transparent, outcomes are measurable and future funding decisions are informed by robust Australian evidence. The evaluation approach is designed to be proportionate, practical and aligned with existing reporting and commissioning frameworks.

10.1 Reporting and evaluation framework

A small, consistent set of core indicators will be used nationally to assess implementation, outcomes and equity impacts. These indicators focus on measuring change in patient capability, use of services and system performance, rather than activity alone.

Core evaluation measures will include:

- PAM® completion and change, including shifts in activation levels and mean score improvement over time
- Service utilisation indicators, where feasible, including avoidable hospital admissions and emergency department presentations for participating cohorts
- Equity indicators, assessing outcomes for priority populations, including First Nations peoples, people in rural and remote communities and people from culturally and linguistically diverse backgrounds
- Workforce capability indicators, including training completion and reported use of activation data in care planning and commissioning

Additional indicators may be included in local evaluation plans as required.

10.2 Reporting and accountability

Reporting will be structured to support accountability at local, regional and national levels. Aggregated reporting will enable PHNs, commissioning bodies and the Commonwealth to monitor implementation progress, variation across regions and trends in outcomes over time.

Reporting frequency and format will be designed to minimise burden on services while providing sufficient insight to support oversight and continuous improvement.

10.3 Independent evaluation and learning

Where appropriate, independent evaluation may be commissioned to assess effectiveness, equity impacts and value for money. This evaluation will support learning, identify areas for refinement and provide government with evidence to inform decisions regarding longer-term integration of patient activation into policy and funding frameworks.

Evaluation findings will be used to inform continuous improvement, ensuring that the approach remains responsive to emerging evidence and system priorities.

Conclusion

Australia's health system is under sustained pressure from chronic conditions, rising demand and workforce constraints. While recent reforms rightly prioritise prevention and person-centred care, their impact is limited without a consistent, practical way to understand and respond to people's capability to manage their health.

Patient activation addresses this gap measuring using the validated Patient Activation Measure (PAM®) providing a proven mechanism to tailor care, target support and track meaningful improvement over time. A substantial body of Australian and international evidence demonstrates that people with lower activation experience higher rates of hospitalisation, emergency department use and healthcare costs, while improvements in activation, particularly movement from the lowest activation levels, are associated with better self-management, more appropriate service use and improved outcomes for people with chronic and complex conditions.

This submission proposes a proportionate, evidence-informed investment to embed patient activation as a funded, routine component of primary care and Chronic Condition Management, integrated within existing Medicare-funded activity. The approach aligns with the direction set by the Strengthening Medicare Taskforce, the Review of General Practice Incentives and broader primary care reform, strengthening the effectiveness of current funding and commissioning arrangements rather than creating new programs. It is scalable across settings and includes clear mechanisms for accountability, evaluation and continuous improvement.

From a fiscal perspective, embedding patient activation represents a low-cost, high-leverage investment that improves the efficiency and impact of existing Commonwealth expenditure. By enabling earlier, better targeted support for people with lower capability to self-manage, this approach reduces avoidable demand, supports more appropriate use of services and moderates future growth in high-cost hospital and emergency care. By acting now, the Commonwealth can equip the system with a practical capability to improve outcomes, support equity and shift care upstream, laying the foundation for a more sustainable, value-based health system over time.

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Partner support and endorsements

Inala Primary Care strongly supports this pre-budget submission and the national rollout of patient activation as a core component of primary care, chronic condition management and social prescribing. Through our work with CFEP Surveys and the Patient Activation Measure, we have seen firsthand how understanding a patient's activation level enables more tailored, effective and equitable care, particularly for people with complex health and social needs. We believe this should be an element considered in funding models and patient risk stratification/eligibility for many programs. Embedding patient activation within routine care supports better self-management, improves engagement and helps practices use clinical time and resources more effectively.

Parkinson's Australia supports the PAM® pre-Budget submission and recognises patient activation as a valuable, evidence-based approach to improving self-management and outcomes for people living with chronic and complex conditions. This proposal aligns with our experience working with AGPAL and CFEP Surveys to strengthen capability, person-centred care and value across the health system.

The Australian Patient Advocacy Alliance (APAA) supports the PAM® pre-Budget submission in partnership with CFEP Surveys, as a practical, evidence-based approach to strengthening prevention, self-management and value for money within primary care and chronic condition management for patients living with chronic conditions.

The Australian Self-Care Alliance (ASCA) actively supports the pre-budget proposals of our members and partners to advance self-care for health. In particular, we recommend the submission of CFEP Surveys to Treasury. While we do not endorse any specific measurement tool, the Alliance recognises the value of measurement in supporting improvement and evaluation and encourages a range of self-care approaches and training initiatives. .

Pain Australia supports the intent of this pre-budget submission to embed patient activation as a core capability within primary care and chronic disease management. Strengthening people's knowledge, skills and confidence to manage persistent pain is essential to improving outcomes and reducing reliance on reactive care, and the Patient Activation Measure offers a practical, evidence-based way to support more person-centred and effective pain care.

Crohn's & Colitis Australia supports the intent of this submission to strengthen patient activation within primary care and chronic condition management. This approach aligns with broader patient advocacy priorities to improve self-management, continuity of care and outcomes for people living with long-term conditions.

Program logic for PAM[®] National Rollout

Objective/s: To improve outcomes, equity and value for money by embedding patient activation as a routine, funded capability within existing primary care, chronic condition management and prevention models.

Needs statement

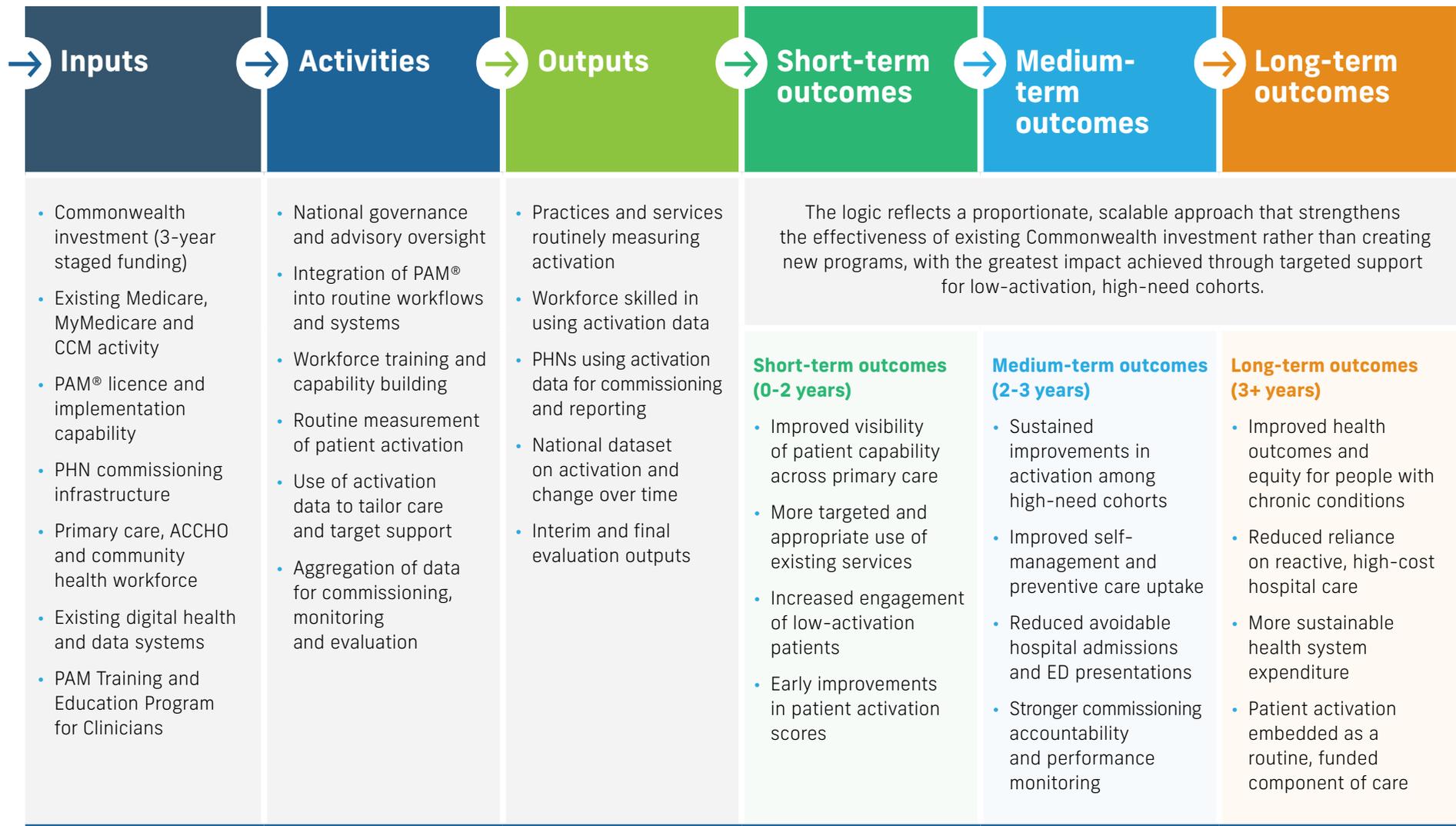
Australia's health system faces rising chronic condition burden, preventable hospital utilisation and workforce pressure. While reforms emphasise prevention and person-centred care, there is no consistent, scalable way to assess and respond to people's capability to manage their health, limiting the effectiveness of existing investment.

Theory of change statement

If patient activation is routinely measured and acted upon within primary care, chronic condition management and prevention, then clinicians and services will have better visibility of people's capability to manage their health and can tailor care and support more effectively. This will enable targeted use of existing services, particularly for people with low activation and high needs, improving self-management, preventive care uptake and engagement.

Over time, sustained improvements in patient activation will reduce avoidable hospital admissions and emergency department presentations, strengthen commissioning accountability, and improve equity of outcomes. By embedding patient activation within existing Medicare-funded models of care rather than creating new programs, the approach strengthens the effectiveness of current investment and supports a more sustainable health system.





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The CFEP Surveys team is passionate, driven and deeply connected to both the patient and the clinician journey. We are committed to closing the loop on healthcare outcomes and experience through a range of practice, patient and clinician feedback tools. Working together each of these tools supports incremental change while working towards professional development, practice improvement and healthcare transformation.

For more information about Patient Activation Measure® (PAM®), contact us:

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