From vision to viability: Funding requirements for effective Early Childhood Hubs

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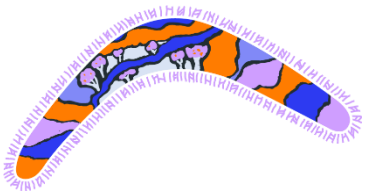

Acknowledgment of Country

Social Ventures Australia acknowledges and pays respect to the past and present traditional custodians and elders of this country on which we work.
‘After the Rains’ by Richard Seden for Saltwater People 2024

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Legal disclosure statement

Contents

1. Glossary

The below list includes key terms used in the report and how they are defined.

- **Aboriginal and Torres Strait Islander Community Controlled Organisation (ACCOs):** ACCOs are organisations that have at least 51% Aboriginal and/or Torres Strait Islander ownership and/or directorship and are operated for the benefit of Aboriginal and Torres Strait Islander Communities.
- **Allied Health:** Allied health refers to a diverse range of non-medical, non-nursing, non-dentist health professionals who provide specialist services to prevent, diagnose and treat various illnesses and conditions. In the context of Early Childhood Hubs (ECHs), allied health services can include physiotherapists, psychologists, occupational therapists and speech pathologists, which are critical for early identification and intervention, as well as supporting developmental milestones for children.
- **Allied Health & Medicine:** Within this report, this term is used to address a broad range of healthcare professionals including allied health and doctors.
- **Childcare Subsidy (CCS)**: This is a subsidy paid by the Australian Government to reduce fees parents pay for approved childcare.
- **Early Childhood Education and Care (ECEC):** Refers to formal education and care for children from birth to school entry, including long day care, preschool/kindergarten and family day care. ECEC was separated from playgroups given differences in the funding model.
- **Early Childhood Hubs (ECH):** Early Childhood Hubs (ECHs) are designed to serve as welcoming, non-stigmatising centres, often on primary school sites, where families can access a broad range of coordinated services, supports and social opportunities. ECHs offer integrated access to high quality services such as ECEC, developmental checks, child health services, family and parenting supports, allied health and other early intervention support while enabling children and families to come together in informal spaces to build social networks. While not all centres describe themselves as “ECHs,” the term is used in our work to capture models that provide integrated access to early learning, family support, health, and community connection. ECHs are a model of Child and Family Hubs, with some form of early learning as the front door.
- **Early Learning:** Early learning refers broadly to the developmental and educational experiences that support children in their first five years. This includes formal ECEC services but also playgroups, supported play and other programs that support school readiness and foundational skills.
- **Glue:** Refers to the relationships, people, systems, and backbone supports that hold services together with a shared purpose to reduce complexity for families, meet their needs and improve outcomes for children[1]. For the purpose of financial modelling, the glue has been costed based on staffing costs for key integration roles (such as ECH coordinators,

[1] SVA, Sticking points: Why the ‘glue’ helps Early Childhood Hubs thrive, [online] available: https://www.socialventures.org.au/about/publications/sticking-points-why-the-glue-helps-early-childhood-hubs-thrive/

community connectors, and backbone support staff) that enable collaboration, coordination, relationship-building and governance as well as funding for glue operating expenses (such as travel and printing) included. Other glue components – including place-focused design – are critical but have not been separately costed due to lack of evidence. Where appropriate, ECHs should further consider incorporating these additional cost components to develop a more complete estimate of the total cost of the glue.

Key conditions for integration (glue)	Description	Costed
Relational infrastructure	Trusted people (such as ECH coordinators, community connectors, and backbone staff) and practices that connect families, services and communities.	Yes – staffing costs
Cross-sector governance and distributed leadership	Ensures services are aligned under a shared vision, with collaboration and authorised leadership shared across sectors to drive accountability for integration.	Partial – includes some governance functions under ECH coordinator staffing and activity costs under other ECH costs category
Coordination systems and backbone infrastructure	Shared processes, data platforms, and organisational supports that help services collaborate effectively while protecting client confidentiality.	Partial – some organisational supports under administration staffing cost and allowance for requirements such as IT, catering, local travel under the other ECH costs category.
Physical and place-focused design	Creates welcoming, culturally safe spaces that make it easy for families to access services and for providers to collaborate, through features like co-location shared spaces, and community-responsive design.	Partial – includes infrastructure and staffing set up costs but does not include co-design
Collective care and accountability	Building a shared culture where services, families, and communities take joint responsibility for outcomes, supported by inclusive governance, cultural safety, community voice, and feedback loops to guide decision-making.	Yes – staffing costs and activity costs under other ECH costs category

- **Long day care:** Long day care (LDC) or centre-based day care is a form of ECEC.
- **Outreach:** These activities are a core role of ECHs and encompass proactive activities undertaken by ECHs to connect with families and communities who may not otherwise engage with services. This includes children and families experiencing entrenched disadvantage, who need this early intervention support the most. Outreach activities include building awareness of ECH offerings, reducing stigma associated with accessing support, building trust and creating pathways for participation. Activities could include community consultations, events as well as informal relationship building activities (e.g. playgroups).
- **Partnered delivery:** This term describes an external organisation delivering services within the ECH. These are typically provided at the ECH without any direct financial cost to the ECH or ECH family participants (although the ECH may accrue indirect costs such as the cost of room maintenance and cleaning costs, utilities etc.). For example, an ECH could have a consultation room and invite the local health service to operate there. This enables them to offer these services to the ECH's family participants. Partnered delivery can facilitate the relocation of already-funded services (such as government-funded health services) to a location and context that increases service reach and better serves community needs. It may also include the provision of short term or once off services on a pro-bono style basis. Partnered delivery may also be described by some ECHs as "in-kind" service provision, as it is a primarily non-financial resourcing strategy for the ECH.

2. Executive summary

Evidence demonstrates that Early Childhood Hub (ECH) models play a pivotal role in supporting children and families to thrive, especially those experiencing socioeconomic disadvantage. Importantly, ECHs enable governments to engage with at risk families that traditionally do not access services or supports. Over the past five years, SVA and our partners have conducted extensive research into ECH models – their potential, current landscape, conditions for success and unmet need. However, detailed cost analysis of the components required to operate an ECH, including services, infrastructure and the integration glue, has remained limited.

This research addresses that gap by exploring cost structures and viable models for ECHs that meet the needs of children, families and communities, while ensuring economic sustainability. The findings aim to inform future funding models that enable scalable, sustainable and responsive ECHs.

To achieve project objectives, SVA undertook four phases of work.

1. **Phase 1**: A targeted literature review identified best-practice features and enablers of successful ECHs.
2. **Phase 2**: Structured interviews and Requests for Information (RFIs) with 10 ECH providers, captured qualitative insights on governance, staffing, service mix, infrastructure, and funding.
3. **Phase 3**: Financial modelling using data from 13 ECHs explored cost structures under various scenarios, validated with stakeholders.
4. **Phase 4:** Insights and data were synthesised to develop a funding framework optimised for economic sustainability and community impact.

Engagement with a diverse set of ECH providers – including ACCOs, non-governmental organisations, government-run models, and collaborative partnerships – revealed diverse income sources, costing components, and the challenges and benefits of different financial scenarios. Interview participants contributed critical perspectives that enriched both the qualitative and quantitative findings.

A ‘building block’ approach was developed to estimate the cost of various ECH components. This framework enables ECH providers to generate indicative costings tailored to specific community needs, community size, infrastructure and service requirements, location-based factors such as urban, regional or rural settings and price indexation. The report also provides further detail on in-house and partnered delivery models and identifies respective conditions for success.

Despite their critical role for children, families and communities, many ECHs face significant funding challenges, including a lack of glue funding and fragmented service funding. In some cases, this is threatening viability. As one provider shared, *“By the end of this year, we all may not have a job.”* Key factors include short term, fragmented, inadequate levels of funding, restrictive grants, lack of support for integration glue and infrastructure maintenance.

The report outlines key findings and recommendations for developing sustainable, impactful and effective ECHs. It highlights the need to shift from short-term fragmented, multi-channel funding to secure, long-term government funding that recognises the glue as an essential component of the ECH model.

Key research findings:

- **Diverse funding sources:** The 13 ECHs participating in this research have highly diverse funding models. Many ECHs are primarily or partially funded through multiple government funding streams, with other key funding sources being philanthropy, fee-for-service, and infrastructure provision. Where funding was not available, services were often provided through partnered delivery. Funding models and their key characteristics vary quite significantly.
- **Glue funding:** Dedicated and adequate glue funding is integral to effective functioning of ECHs, but it is often unfunded or reliant on short term philanthropic grants. ECHs with funded glue secured significantly more partnered delivery services, established and operated strong governance structures and supported higher levels of integration. In fact, ECHs with funded glue provided on average 22 times more dollar value in partnered delivery services than those without. Given the importance of integration, even where ECHs had no glue funding, they still worked hard to provide some glue functions, drawing on other revenue sources and staff time.
  Fragmented service funding and inadequate delivery: Service funding was particularly fragmented, with significant variability of funding sources, and many ECHs reliant on multiple funding sources and partnered delivery. This creates challenges for planning, integration and sustainability. Many ECHs face challenges in offering sufficient services to meet community needs, citing long wait lists and lack of critical services. In particular, many participating ECHs highlighted the critical shortage of allied health supports in their communities. Although there is a general shortage of allied health services across the country, this is particularly acute in in areas with significant socioeconomic disadvantage.
- **ECEC viability:** Inclusion of ECEC did not improve financial sustainability of ECHs; instead, it generally increased viability risk, requiring cross-subsidisation from other revenue sources and/or ECH staffing. This suggests that the current ECEC funding model is not fit for purpose for long day care provision in communities experiencing socioeconomic disadvantage. Despite these financial challenges, ECH providers continue offering ECEC due to its developmental, educational and relational benefits. This finding underscores the urgent need for reform of the ECEC funding model. The inadequacy of the current model means many children who stand to benefit most are missing out on critical learning opportunities.
- **Infrastructure challenges:** Fit-for-purpose infrastructure is critical to foster integration and meet community needs. Current funding models require infrastructure provision at minimal cost, with most ECH providers operating rent-free, often in government owned buildings collocated with schools. Where providers bear infrastructure, maintenance and repair costs, the financial strain is significant given tight operating budgets. This has implications for both current providers and the establishment of new ECHs.
- **Funding model:** A secure, long term, flexible funding model sufficient to meet actual costs of ECH delivery (which includes glue, services and infrastructure) is required to ensure the ongoing sustainability and viability of ECHs and their delivery of critical integrated services to children and families. Our analysis shows the indicative cost to set up an ECH in metro NSW to serve 100 families, including up to 200 children (with 60 ECEC places) as $2.19m including $1.39m for infrastructure costs for a partnered delivery model (with relevant loadings such as geographic additional, recognising the different cost profiles for rural, regional and remote areas). This could be built around a primary school and ECEC centre as a gateway to increase service access, intervene early and improve child and family outcomes. With existing funding entitlements and infrastructure, primary schools may be preferred ECH sites: glue staffing being the core additional cost for implementation. Ongoing $0.8m per annum glue and operational funding, with relevant additional loadings as needed, is a low-cost high impact investment in these children and families.

- **Partnered delivery:** Partnered delivery is the preferred ECH model in communities where quality services were available, accessible and appropriate, except where the ECH provider has specific service expertise and capacity. This unlocks the existing funding in the system, expanding reach and impact of existing government (and non-government) services, enhancing integration across the system, and avoiding service duplication. Procuring and integrating services within an ECH for partnered delivery is contingent on sufficient glue funding.

Key recommendations

For all recommendations, deep engagement with communities on their specific needs, priorities and gaps in child and family supports is a critical first step to better understand and meet the needs of children and their families. This should include strong commitment to shared decision-making, self-determination and cultural governance, in alignment with Closing the Gap Priority Reform One[2].

1. **Integration:** Federal, state/territory and local governments prioritise integration in all reform opportunities to work towards a joined-up child and family system that enables seamless provision of child and family centred services and supports to communities experiencing significant socioeconomic disadvantage**.**
2. **Long term funding mechanism:** Federal, state and territory governments agree on and implement a long-term, adequate funding model to support establishment and ongoing operation of ECHs in areas with significant socioeconomic disadvantage, including adequate glue funding, flexible funding to support priority family needs, adequate rent, ongoing maintenance and building management costs (as relevant respectively). Prioritisation on primary school sites is recommended (where appropriate), with existing funding entitlements and infrastructure provision often providing a preferred setting**.**
3. **ACCO growth and funding:** Federal and state/territory governments establish a specific funding mechanism for integrated Aboriginal and Torres Strait Islander ACCO early years services in accordance with the SNAICC ACCO Funding Model report[3], ensuring proportionate investment based on child need, and support mechanisms to grow and sustain the ACCO early years sector.
4. **Infrastructure:** Federal, state and territory government infrastructure grants, including the Building Early Education Fund (BEEF), reflect actual ECH property development costs, and are accompanied by funding for ongoing maintenance and building management costs where ECHs own buildings, or property rental and related costs where they do not.
5. **Building Early Education Fund:** BEEF investments include at least $1.39 million, with additional loadings for geographical complexity, for set up of an ECH around every long day care service established through the fund, to unlock service access, intervene early and improve child and family outcomes.
6. **ECEC funding reform:** Australian Government reform the ECEC funding model to ensure services are funded for the full operational cost of ECEC service provision (through fees, subsidy and equity loadings) including more experienced and above ratio staffing in communities with significant socioeconomic disadvantage.

[2] Parliament of Australia (2020). Priority Reforms. Closing the Gap. Retrieved from https://www.closingthegap.gov. au/national-agreement/priority-reforms

[3] SNAICC (2024). *Funding Model Options for ACCO Integrated Early Years Services: Final repor*t. https://www.snaicc.org.au/wp-content/uploads/2024/05/240507-ACCO-Funding-Report.pdf

7. **Interim expansion of Community Child Care Fund (CCCF):** While the ECEC funding model is under review, the Australian Government expand the CCCF to fund the ECEC operational gap and integration glue for ECHs. Funding for ongoing maintenance and building management costs where ECHs own the building or property rental and related costs where they do not, is also a critical component. SVA recommends prioritisation of existing ECHs with no glue, or those facing sustainability risks, to unlock significant impact quickly.
8. **Thriving Kids:** The Australian Government embed ECHs within the Thriving Kids Program as one key pathway for implementation to support integrated provision of supports for children with developmental needs.
9. **Further costings research:** Federal, state and territory governments, philanthropy and the sector collaborate on a next phase of larger scale research on the cost of provision of high quality ECHs, to complement and accompany the Australian Government Early Education Service Delivery Prices Project.
10. **SROI investment:** Sources of non-government funding such as philanthropic funding invests in Cost Benefit and Social Return on Investment research to build an understanding not only of the costs of ECH provision, but the social and economic benefits. The opportunity that ECHs provide for early intervention should be included.
11. **Strengthen articulation of the glue:** ECH leaders continue to strengthen the articulation and measurement of the glue, supporting it to become a more visible and explicit deliverable.
12. **Test Building Blocks model:** Organisations interested in establishing or transitioning into an ECH work with SVA to test the Building Blocks model articulated in the report.

This research strengthens the evidence base on ECH costings and funding requirements to inform the design of sustainable funding models for ECHs. It highlights the urgent need for coordinated long-term investment that reflects the actual cost of delivering integrated, community-responsive services in communities experiencing significant socioeconomic disadvantage. With the right investment and policy reform, ECHs can be scaled and sustained to deliver lasting impact for children and families.

The report concludes that by centring integration and embedding ECHs within current reforms—such as the Australian Government Service Delivery Price Project, Building Early Education Fund and Thriving Kids Program, we can join-up our systems around children and families. By committing to long-term, fit-for-purpose funding for ECHs as part of creating a universal early learning system, governments and partners can ensure children experiencing hardship have the supports they need to thrive.

3. Introduction

Early Childhood Hubs (ECHs) are service and social hubs where children and families can access key services and connect with other families. They usually take the form of a centre that provides a range of child and family services, including early learning programs, maternal and child health, allied health, and family support programs. ECHs also provide access to a range of tiered services to support families with broader challenges they may be facing. They offer a space where families can come together to socialise and build social networks, a critical component to creating self-sustaining, cohesive communities. ECHs are a model of Child and Family Hubs, with some form of early learning as the front door.

> *"I feel safe, welcome and comfortable here"* - Family member[4]

ECHs aim to connect families with services earlier, more easily, and in ways that feel relational rather than transactional. ECHs often act as a "soft entry" to supports that are non-stigmatising and integrated. This is supported by being embedded within everyday community spaces like schools or early learning centres, and active engagement with communities in existing community spaces.

One of the key challenges arising from the absence of a national framework or policy for ECHs is the lack of a clearly defined ECH model and a universally accepted definition. The structure and interpretation of ECHs varies significantly across providers and jurisdictions. Not all describe themselves as ECHs, preferring to use an alternative label.

Yet, while ECHs operate under a variety of names and within diverse local contexts, they share a vision for their communities. ECHs participating in this research universally shared their vision for:

- **Children to grow up healthy, happy and ready to learn**, supported by aligned services including early intervention, from birth through to school entry
- **Families to be engaged partners** in their children's development, empowered through access to knowledge, support and networks for decision making
- **Strong two-way engagement between ECHs and communities** ensuring that ECHs align with and continually meet evolving community needs
- **Services targeted to individual children and family needs and made more approachable and accessible** by ensuring better coordination across a child's development as well as knowledge sharing across the ECH to ensure services are holistically targeted to meet child and family needs.

> *"We're more connected to others and ourselves"* - Family member[5]

ECHs may also provide additional services such as school readiness supports, which help to reduce barriers to participation and improve transitions into formal schooling. This includes tailored early childhood education, parent education and coordinated approaches to learning across early years

[4] The Australian Centre for Social Innovation. *In their words: Family perspectives on the power of Early Childhood Hubs* [Report], Social Ventures Australia, November 2025.

[5] The Australian Centre for Social Innovation. *In their words: Family perspectives on the power of Early Childhood Hubs* [Report], Social Ventures Australia, November 2025.

and primary school. Other services may include cultural safety and community leadership, seeking not only to improve outcomes for children but to foreground community identity and voice.

How families experience Early Childhood Hubs[6]

Families experience ECHs as life changing communities and services that support whole of family wellbeing. Recent research with 17 families using ECHs identified five "stepping stones for change" through hubs to transform outcomes for children and families:

1. **Safe and trusting relationships** so families feel confident to seek help and do so earlier.
2. **Children's wellbeing and development** so more children are able to thrive.
3. **Parent confidence and capability** empowering parents to become stronger caregivers.
4. **Wrap-around home support** increasing independence, food security and financial stability, reducing crisis impacts.
5. **Ongoing connection and belonging** so communities sustain themselves.

Without hubs, families often face fragmented service systems that require them to retell their stories and navigate barriers such as stigma, trauma, housing instability, or financial stress. Hubs bridge these gaps. ECHs become community anchors, not only delivering better outcomes for children and families, but strengthening entire communities.

Evidence demonstrates that integrated ECH models play a pivotal role in supporting children and families to thrive, especially those experiencing significant disadvantage[7]. However, existing ECH supply is insufficient to address community needs. A lack of national framework or policy, inadequate funding models and workforce shortages limit the sufficient provision of quality and effective ECHs[8]. Research and evaluations have attempted to identify essential features, components and enablers for ECH. However, financial analysis of ECH, including sources of funding, key services and facilities is limited (see Literature Review).

Across Australia, there are an estimated at least 231[9] ECHs operating under various models (and over 470 Child and Family Hubs, which in addition to ECHs include health and community organisations as the front door as well as virtual offerings). While the majority of ECHs are based within Queensland (58) and South Australia (51), Northern Territory (1:~16.k) and Tasmania (1:~24k) had the greatest number of ECHs proportional to population.

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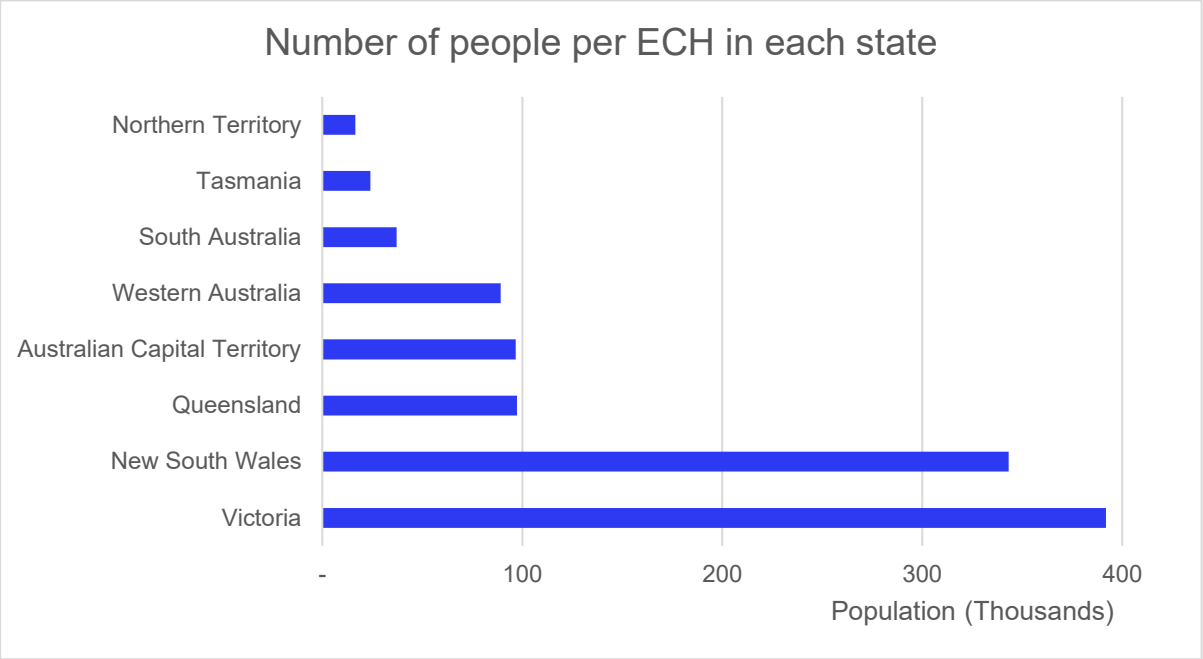
[6] The Australian Centre for Social Innovation. *In their words: Family perspectives on the power of Early Childhood Hubs* [Report], Social Ventures Australia, November 2025.

[7] [xi] Hopwood, N. (2018). *Creating Better Futures: Report on Tasmania's Child and Family Centres*. UTS School of Education. https://static1.squarespace.com/static/5a13bc2aaeb62559b9c7b21e/t/5c04da21575d1f312eafb455/1543821953254/Hopwood+CFC+Report+2018.pdf ; TBS (2022). *Impact Report: TBS Early Years Places in Queensland*, prepared for The Benevolent Society by Social Outcomes. https://www.benevolent.org.au/get-involved/early-years-places-impact-measurement-framework; Department for Levelling Up, Housing and Communities (2022) *Early Help System Guide: A toolkit to* assist local strategic partnerships responsible for their Early Help System. HM Government. https://assets.publishing.service.gov.uk/media/628de13be90e071f5f7e1bd2/Early_Help_System_Guide.pdf; Lord, P., Kinder, K., Wilkin, A., Atkinson, M. and Harland, J. (2008). Evaluating the Early Impact of Integrated Children's Services: Round 1 Summary Report. Slough: NFER.

[8] https://www.socialventures.org.au/wp-content/uploads/2024/07/DAE_SVACCCH-Exploring-need-and-funding-for-ICFCs-FINAL-November-2023.pdf.

[9] https://www.socialventures.org.au/wp-content/uploads/2024/07/DAE_SVACCCH-Exploring-need-and-funding-for-ICFCs-FINAL-November-2023.pdf.

Figure 1 – Number of people per ECH in each state

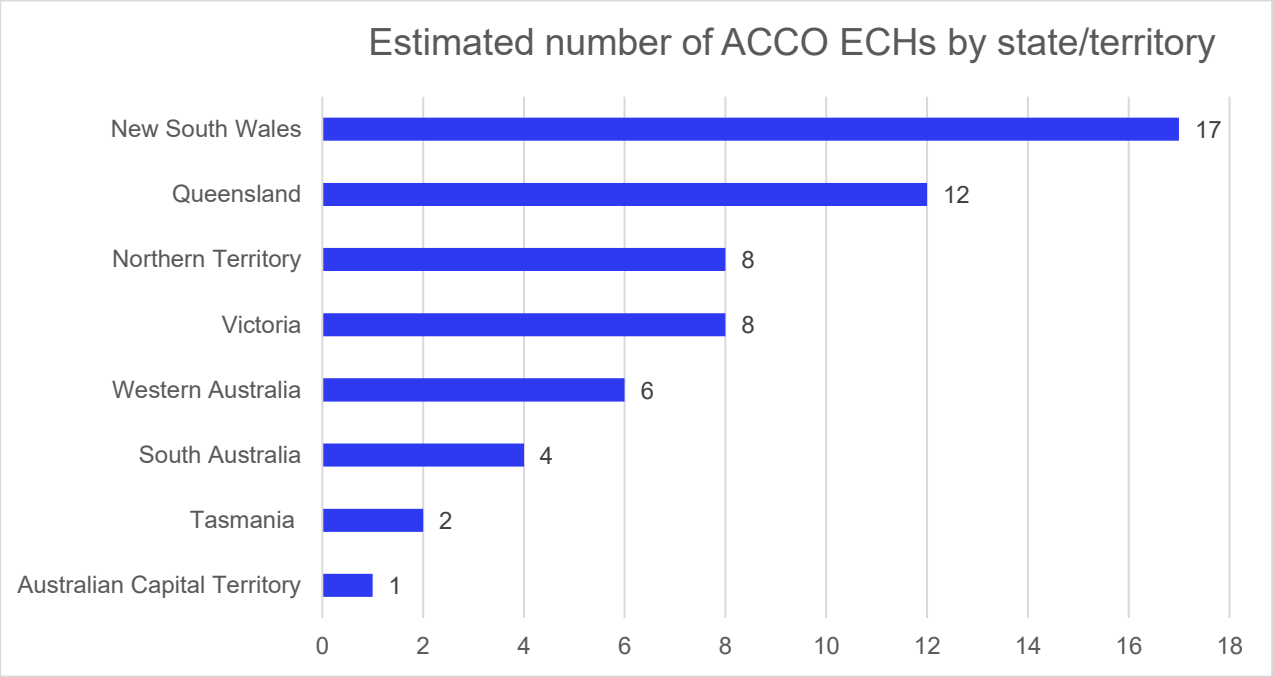


The structure of ECHs varies – including integration with early learning centres, primary schools, allied health services and non-government organisations. Some ECHs are provided by Aboriginal and Torres Strait Islander Community Controlled Organisations (ACCOs), offering a culturally grounded model of care. Connection and accountability that ACCOs have to their communities makes them uniquely placed to identify the services and supports that are most needed and impactful at a local level. ACCOs play a key role in meeting a child and family's need for a safe space to build cultural pride, confidence and resilience and to build the strengths and skills of their children and have specific requirements beyond that of the ECH sector. Supporting and growing a thriving Aboriginal and Torres Strait Islander Community Controlled sector is crucial to supporting Aboriginal and Torres Strait Islander children and communities to thrive. This research included engagement with a limited sample size of two ACCOs. In relation to the unique features and funding requirements of ACCO ECHs, we refer to the work of SNAICC and in particular the SNAICC "Funding Model Options for ACCO Integrated Early Years Services report".[10]

[10] See further; SNAICC Report on Funding Model Options for ACCO Integrated Early Years Service.

There are 58 ACCO ECHs nationally, the proportion of ACCOs by state can be seen in Figure 2.

Figure 2 – Estimate number of ACCO ECHs by state/territory

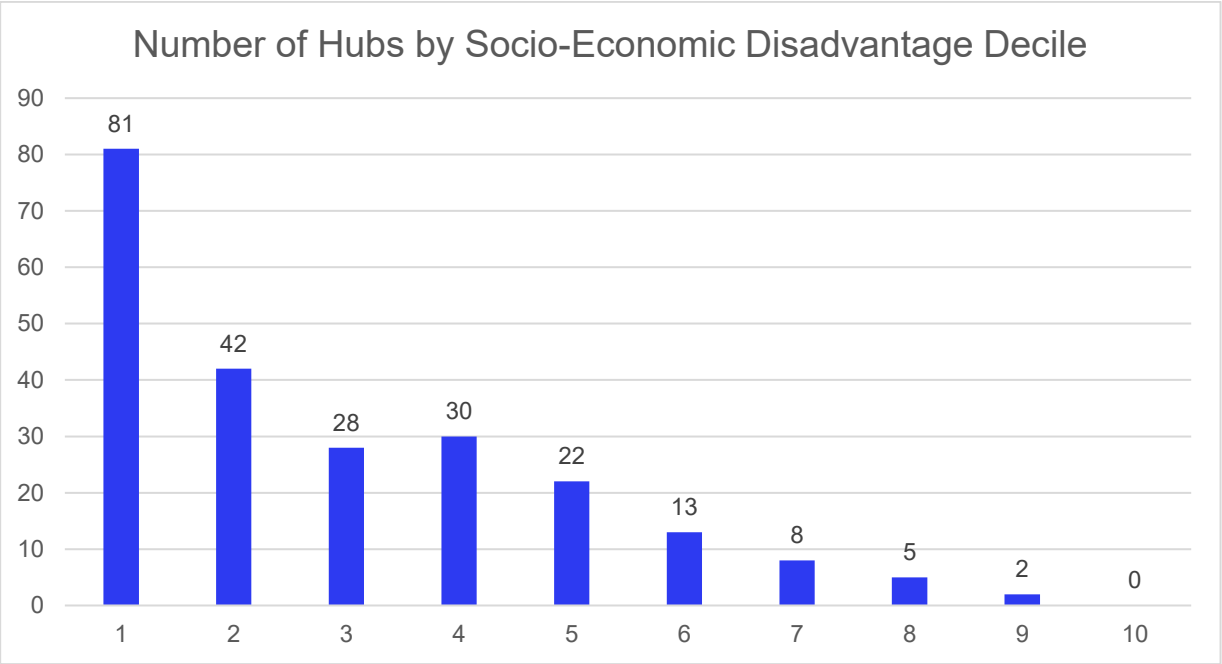


Of the 231 ECHs nationally, a significant majority are in areas experiencing high levels of socioeconomic disadvantage. As shown in the Figure 3 below, 81 ECHs are situated in the most disadvantaged decile (Decile 1[11]), and 42 more are in Decile 2, the second lowest disadvantaged decile (ABS Socioeconomic Index, 2021). Together, these account for more than half of all ECHs[12] (123 out of 231). The number of ECHs steadily declines across the deciles, with very few located in more advantaged areas. This distribution highlights the placement of ECHs as an enabler for communities experiencing socioeconomic disadvantage to have a place to build connections and access critical early learning, allied health and family support services.

[11] Per https://www.abs.gov.au/methodologies/socio-economic-indexes-areas-seifa-australia-methodology/2021, SEIFA is a collection of four indexes, summarising socio-economic conditions in an area.

[12] This refers to hubs classified as ECHs within the definition used in this report.

Figure 3 – Number of ECHs across various socioeconomic disadvantage deciles (1 being lowest, 10 being highest)



A defining feature of effective ECHs is the presence of dedicated integration roles, often known by various titles such as Community Connectors, Partnerships Coordinators, or Family Engagement Workers. These individuals are critical to ensuring cross-service coordination and collaboration, fostering relationships and building trust with families. Throughout this report, this function is incorporated in the glue – an essential yet often under-recognised and poorly understood function of the ECH model that enables integrated service delivery. In addition to this relational infrastructure, the glue also incorporates other conditions of integration such as coordination systems and backbone infrastructure (including information sharing, systems and processes), governance and distributed leadership, and collective care and accountability [13].

Project purpose

It is critical to build a deeper understanding of ECH cost components and funding requirements, with an increasing number and scale of ECH models across Australia. Many ECHs are emerging in communities driven by child and family need, outside of a formal model. This knowledge base is important in developing effective funding models which can support ECHs to deliver on their objectives and to effectively embed ECHs within ECEC, and other child and family systems. This research seeks to address this gap.

This research explores how ECHs may be designed and supported to deliver financially viable and sustainable ECH services. It builds the evidence base to inform future funding of ECH models that are scalable, sustainable, impactful and responsive to the needs of families and local communities – particularly those experiencing socioeconomic disadvantage. Specifically, the project had three key objectives:

[13] SVA, 'Sticking points: why the 'glue' helps Early Childhood Hubs thrive,' 2025 [online], available: https://www.socialventures.org.au/wp-content/uploads/2025/09/glue-policy-paper.pdf.

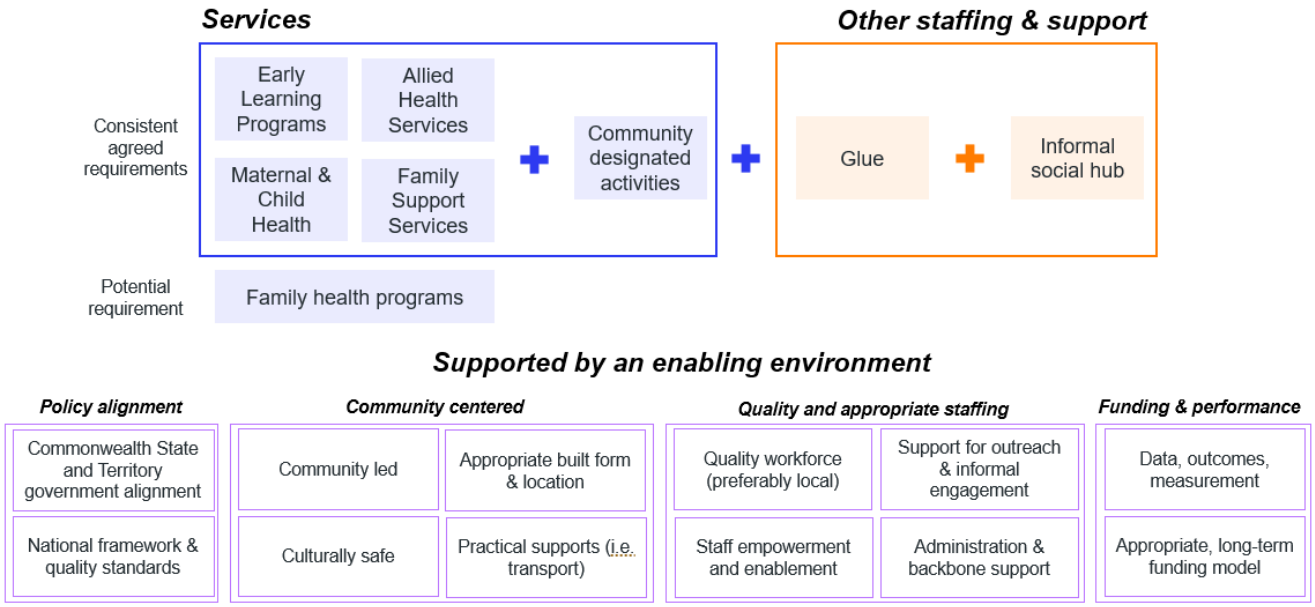
1. To **test the hypothesis that ECHs with ECEC services** have greater financial sustainability driven by use of ECEC service revenue to cross subsidise other costs associated with the ECH including the glue.
2. To **develop a financial model for ECHs** demonstrating costs and revenues associated with their various components, including service delivery, glue and infrastructure.
3. To **recommend minimal and optimal service propositions** for ECHs based on specific community features, ECH provider consultations, written responses and financial model outputs.

4. Literature review findings

As part of this research, SVA undertook a review of available literature to understand the current body of research on ECH funding models. We also explored what previous research had identified as the key qualitative and quantitative considerations for effective ECH models that met financial and community requirements.

Key publications (see Appendix A) reveal a broad consensus on essential ECH components to meet community needs and deliver social impact. These are summarised in Figure 4:

Figure 4: ECH key components from literature review



The literature review demonstrates various efforts to conduct high level costings of aspects of ECHs. This includes:

- Infrastructure development and maintenance costs.
- Cost of delivering core services: in two studies, this was costed at a very high level with significant variation, driven in part by vastly different service offerings.
- Estimates for the staffing and operational costs associated with integration and relational work (the glue): both staff allocation (FTE) and costs varied significantly across three studies.
- Cost of delivering community-designated services: the two studies identified have significant variability which can be explained by the difference in services provided.
- Sensitivities: different factors were articulated as drivers of proportionally increased costs including centre or population size, vulnerability, remoteness, and size/sophistication of parent organisation.
- Staffing costs: some studies used data from a single case study, while others took estimates. This resulted in significant variability. Services in rural and remote areas were also more likely to experience higher staffing cost due to limited workforce supply outside of metro areas.
- ACCO specific funding model: SNAICC completed a detailed ACCO Funding Model Options Report to consider costings for an ACCO ECH and potential funding models to support ACCO

ECHs to provide holistic, culturally responsive services. It is the most recent public report on ECH cost modelling. The report calls for a needs-based block funding approach that exists outside of the CCS, and provides full funding for delivery of all services, at no cost to children and families. This report considered Deloitte's Access Economics cost modelling as a base with the following:

- 4 FTE glue staff (2 directors, 1 centre manager, 1 admin support) - with costs estimated to be ~$62.3k per FTE
- 6 core staff to provide all ECH services such as ECEC, MCH, allied health, transport, community and cultural and transport – with costs estimated to be an average $70k per FTE
- Flexible funding for community designated services – 25% of staff and operational funding
- Operational non-staff costs – 25% of staff costs
- Maintenance costs – estimated to be 10% of infrastructure costs
- The base model estimates an annual cost of ~$1.2m per annum for the above. The model considers population size, remoteness and vulnerability to apply various loadings. Dependant on the loading, this may apply to specific components or all costs.

Overall, the literature review reveals that ECHs are predominantly dependant on multiple funding sources that can be insecure, insufficient, short term and requiring significant administration overhead. Funding sources may be various state, territory and Federal government departments as well as philanthropy. Furthermore, ECHs may struggle to identify the true cost of the services they deliver due to regulatory challenges in terms of sharing data across services.

Other funding challenges include:

- **Regulation complexity:** Given their integrated service offering, ECHs are reliant on government funding and must adhere to regulation from different departments and levels of government, creating complexity and at times requirements that do not align.
- **Burden of reporting:** ECHs are often reliant on multiple funding streams. Each funder generally has their own process for reporting, which results in administration overheads for the ECH.
- **Insufficient funding:** ECHs often experience a shortfall in funding to meet requirements, impacting the quantity and quality of services the ECH offers, as well as the number of children and families that can be supported.
- **ACCO-specific challenges:** ACCOs experienced a lack of funding for cultural activities, additional support required to build community trust, and challenges accessing government subsidies.

In terms of enhancing ECH feasibility and viability, the literature reviewed focused mainly on funding model reform and improvements to existing funding streams. Several other opportunities were considered at a high level:

- **Infrastructure:** opportunities to leverage existing community infrastructure to reduce costs and expedite the delivery of ECHs.
- **Workforce participation:** particularly for ACCOs, culturally safe and appropriate education and ongoing professional development and upskilling pathways can support the engagement of community members in ECH roles.
- **Innovative partnerships:** Innovative partnerships could be considered to enable continuity of service provision in the context of healthcare worker shortages.
- **Economies of scale:** Clustering ECHs or early childhood/community services may help to reduce the costs of ECH management, glue, infrastructure and service delivery.

5. Methodology

The findings in this report are based on the following:

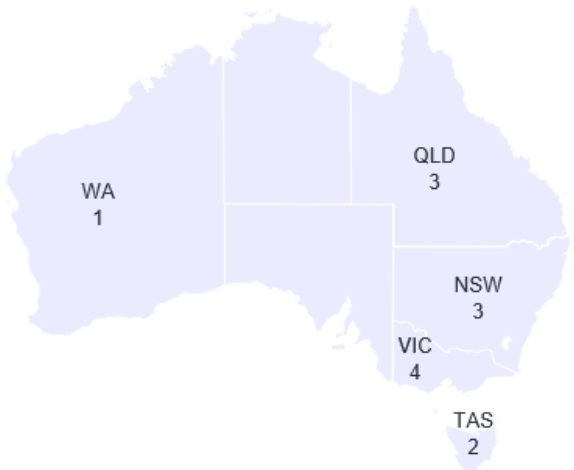
Phase 1 involved a **literature review** of research reports and documentation that considered areas including ECH best practice, need and funding models, to identify the key features and enablers of effective, integrated ECHs. This foundational research helped shape the criteria for assessing viability and guided the development of the interview tools.

Phase 2 involved a series of **structured interviews** with ECH providers (including ACCOs, non-government organisations, government operated models and collaborative arrangements), followed by detailed Requests for Information (RFIs) to supplement and validate data collected through the interviews. As part of this, 10 ECH providers were consulted, with 13 ECHs incorporated within the financial modelling as part of this project (please refer to Figure 5). Interview participants were leaders within their respective organisations, including executives, service directors and other operational managers. These participants provided valuable insights into the topics explored through interviews, including:

- Purpose and vision
- Staffing and integration roles (referred to in this report as the glue)
- Governance
- Outreach and community engagement
- Service provision
- Early learning
- Infrastructure
- Funding and financial viability

To complement and validate the interview insights, participants were also invited to complete a detailed RFI. These RFIs enabled collection of more granular data around service profiles, staffing models, and funding structures.

Figure 5: ECHs used in financial modelling by state



Phase 3 focussed on **building out an ECH financial model** covering data from 13 ECHs that included major ECH cost categories including the glue. The modelling incorporated scenario analysis to identify different ECH operating costs. As part of this phase, initial findings were shared with participating ECH providers for validation.

Phase 4 synthesised findings from the first three phases, developed a **"building blocks" costing model** to estimate the cost of ECH components, and proposed key recommendations for economically sustainable ECH funding that meets community needs.

Research limitations

Although this research gathered feedback from a diverse group of ECH participants, the overall cohort size was limited. Further large-scale studies are necessary to obtain a more significant sample and to capture a wider range of experiences.

We also note limitations around the data that was obtained. Due to confidentiality considerations, some ECH providers were limited in the type and quantity of data they were able to provide, as such, additional desktop research and analysis was undertaken to derive estimates. Where services (ECEC or other) were provided via partnered delivery, their revenues and costs were typically not obtained as part of this research.

5.1 The building blocks model

ECH service delivery models vary as each ECH is tailored to meet the unique needs of its community. Our engagement with ECHs demonstrated the various ways that ECHs can be designed to meet community needs, while also leveraging existing service and infrastructure provision in the community. Our consultations demonstrated that all aspects included in the building blocks model are core components of an ECH. However, while some may be staffed and operated by the ECH provider, others may be provided through partnered delivery.

To understand the true costs of an ECH, these components have been grouped into distinct "building blocks". A breakdown of the building block approach can be found below in Figure 6.

Figure 6: ECH building blocks approach

Cost Categories	Glue staff	Services staff	Infrastructure	Other operating costs
Cost Components	Glue	Early Learning & ECEC	Consult rooms	IT, electricity, cleaning etc.
		Maternal & Child Health	Meeting / community rooms	
		Family Support Services	Informal space	
		Community designated activities	Play environment	
		Allied Health	ECEC space	

The building blocks approach categorises ECH costs into four key cost types: glue, services, infrastructure and other operating costs. It enables ECH providers to generate indicative ECH costings tailored to specific community needs, size of community, infrastructure and service provision requirements, location-based factors such as urban, regional or rural settings and price indexation.

In summary, the building block approach allows us to:

- Disaggregate costs into consistent categories
- Identify components that will be provided by ECH staff and components that are provided through partnered delivery, operating from ECH premises
- Identify new ECH infrastructure requirements, with consideration of existing infrastructure within the community
- Support flexible cost modelling, enabling comparison across various models or archetypes and allowing ECH providers to scale up or down various ECH aspects, dependant on their specific community needs.

This framework provides a clear structure that will be referenced throughout the report to analyse and cost the various ECH funding and service models.

5.2 The building blocks model methodology

A ‘unit cost’ methodology was used to inform underlying cost components (“units”) for each ECH building block (glue staff, services staff, infrastructure and other operating costs). One full time equivalent (FTE) staff represents one unit for glue staff and services staff, and square metre represents one unit for infrastructure. One unit of aggregate dollar value was used for other operating costs, resources and fixtures. Each unit has a corresponding unit cost. The unit cost is variable and will require periodic updating to reflect changes in inflation, award rates, and market price of infrastructure. It will also need to reflect prices in various geographies which includes considerations for state, territory, urban, regional and rural locations. ECHs can use a multiple of appropriate units to cost specific ECH building blocks based on number of children and families serviced, community needs, complexity of service provision, available resourcing within the community and proportion of direct or partnered delivery service provision. The ECH provider can also flexibly allocate units to address the type of need as well as the type of resources they have available. For example, the administration FTE (incorporated within glue) could be utilised for a range of staffing requirements necessary to support the ECH, including Finance, IT, or a training role to support the ongoing training and education needs of ECH staff.

6. Funding sources and cost components of Early Childhood Hubs

This section synthesises and analyses data collected on the funding sources and cost components of participating ECHs. It explores the benefits and challenges of different ECH funding models.

6.1 ECH income and contributions

ECHs have several different sources of income, including:

- Government
- Philanthropy
- Fee revenue

The ECHs consulted mainly relied on government and philanthropic funding as their primary income sources. Fee revenue was largely restricted to ECEC services and was rarely adequate to cover the broader operational costs of the service, which in turn often needed cross subsidisation.

In addition to income, significant partnered delivery services were often provided to ECHs, expanding their capacity for impact. This was a defining feature, and in some cases a core component, of the ECH funding model.

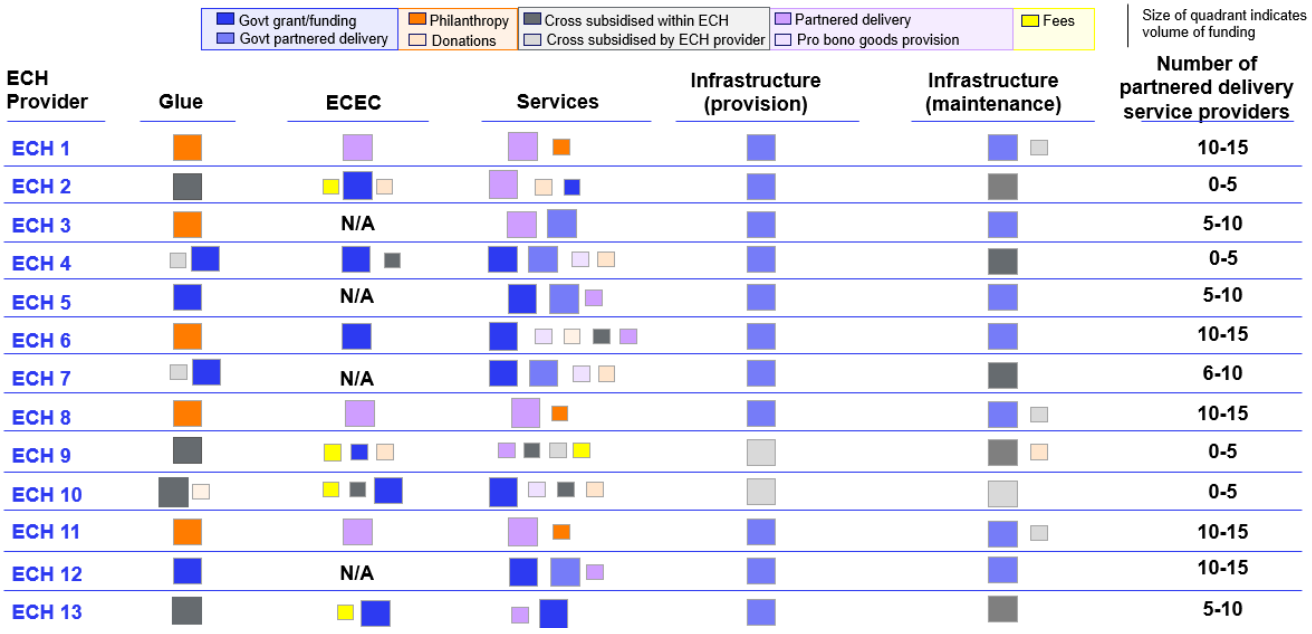
As seen in Figure 7 below, the funding sources for ECHs were varied across financial income and partnered delivery service provision. Key observations about ECH income and contributions are as follows:

Glue: It was typically either philanthropically funded, incorporated within a broader government funding model or unfunded. Where unfunded, a level of cross subsidisation was required from other staff, or revenue streams within the ECH.

Services: Service funding was particularly fragmented, with significant variability of funding sources across each ECH, and many ECHs reliant on multiple funding sources and partnered delivery for the services they offer. When provided, ECEC service was often provided through partnered delivery if glue was funded. However, when ECHs provided ECEC in-house, they typically relied on multiple funding streams.

Infrastructure: Infrastructure was typically government funded and provided in-kind with no or minimal rental charge or owned by the ECH provider. However, funding for infrastructure related costs such as cleaning, maintenance and repairs was more fragmented, noting that, where premises are government provided, in some cases government will provide these services whereas in others these were the responsibility of the ECH provider to fund, or split between parties subject to a negotiated agreement.

Figure 7: Funding sources for various ECH components[14]



ECH Provider	Glue	ECEC	Services	Infrastructure (provision)	Infrastructure (maintenance)	Number of partnered delivery service providers
ECH 1						10-15
ECH 2						0-5
ECH 3		N/A				5-10
ECH 4						0-5
ECH 5		N/A				5-10
ECH 6						10-15
ECH 7		N/A				6-10
ECH 8						10-15
ECH 9						0-5
ECH 10						0-5
ECH 11						10-15
ECH 12		N/A				10-15
ECH 13						5-10

Figure 7 indicates the significant variability within funding models that underpin ECHs. This reflects various factors including differences in state-based funding models, access to philanthropic funding and whether there were services operating within the community that could be relocated to the ECH, to meet ECH family participant needs. This has implications for service programming, level of integration and governance.

Gathered data identified the following three funding sources and partnered delivery service provision. To meet their community needs, ECHs by necessity adopted a hybrid style model, leveraging multiple sources of income and contribution listed below.

1. Government funding
2. Targeted philanthropic funding
3. Fee for service
4. Partnered delivery service provision

6.1.1 Government funding streams

Many ECHs are primarily or partially funded through various government funding streams. In certain states, this includes specific state and territory government funding streams for implementation and operation of an ECH or multiple elements of an ECH. In these cases, government support could also extend to partnered delivery service provision such as locating state and territory government funded health providers onsite or providing some level of maintenance and cleaning services. These funding streams are most commonly from state or territory Departments of Education, Communities or Social Services, and could incorporate grant funding and in-kind infrastructure provision. Many providers noted that while many core services are covered, funding is not sufficient to meet key community needs, with ECH providers often seeking additional funding and/or support elsewhere. However,

[14] ECHs may have a multitude of funding streams, with significant overheads associated with application and reporting obligations. This table does not demonstrate the number of number of funding streams from each category that ECH providers receive. This table is indicative. Where information is unavailable or incomplete, assumptions have been made.

notwithstanding this, these funding streams are typically considered to be stable, longer term and cover multiple ECH cost categories. When the funding covers maintenance this not only provides funding for these core requirements but also reduces overheads by not requiring the ECH provider to dedicate staff time to engaging in facility management.

Beyond this core funding, or where more holistic ECH funding is unavailable or inaccessible to the provider, some ECH providers may seek additional State or Australian Government grants to provide specific services or programs. Specific service provision funding often covers direct costs but rarely fully addresses related expenses like administration, facilities, and integration, resulting in a funding gap that the ECH struggles to bridge.

> *"It can be a struggle to access government funding because you need the staff to know how to apply for it."* - ECH provider

6.1.2 Models supported with targeted philanthropy

A smaller number of ECHs have specific roles or services that are predominantly funded by philanthropy. Several ECH providers had explicit philanthropic funding for glue. In these cases, philanthropic contributions involve collaboration between ECH providers and philanthropy which can enable knowledge sharing, insights and a focus on broader systemic implementation of the model. Some philanthropic contributions also focus on providing or subsidising a single service, delivering an event or purchasing necessary item/s.

When philanthropic funding is core to the ECH, it may be effective for innovation, implementation and initial operations. However, several providers noted that their core philanthropic funding was not intended to be provided on an ongoing basis. The expectation was that once the model was proven, other funding sources, such as government would be secured to ensure ongoing ECH sustainability. Given variability in philanthropic funders, features of funding also varied, including duration of funding, flexibility and reporting.

6.1.3 Fee income – and financial sustainability hypothesis

Fee income was limited source of income for ECHs. It typically related to the provision of LDC. One key objective of this project was to test the hypothesis that ECHs with ECEC services would demonstrate greater financial sustainability, driven by the ability to use ECEC revenue to cross-subsidise other operational costs, including the conditions of integration known as the glue. Findings from the ECH provider consultations and financial modelling did not support this hypothesis.

In practice, ECEC services, particularly those operated in-house, were loss making, with fee income insufficient to cover service delivery costs. This reflects realities of operating in communities facing socioeconomic disadvantage, where meeting complex needs requires more experienced staff, higher staff ratios and above-award wages – while families often have limited capacity to contribute through fees. ECEC funding reforms alone may not improve viability where higher staffing ratios are needed, inclusion funding is insufficient, and they do not benefit families who are ineligible for support (e.g., refugees)

Despite these financial challenges, ECH providers continued to offer ECEC services due to their developmental, educational and relational benefits for children and families. These findings underscore the need for dedicated, sustainable funding for all core ECH components, including glue

and early learning, rather than relying on ECEC revenue to support broader service integration. ECHs with ECEC are at greater viability risk than those without, with ECEC generally being loss-making and requiring cross-subsidisation from other ECH revenue sources

Challenges

Despite ECHs being critical to supporting families, children and broader communities, they experience significant funding challenges. This research identified the following stress points:

- **Short-term, fragmented funding.** This at times includes funding renewals as short as 12 months, creating significant uncertainty and instability and requiring high staff resourcing for identifying opportunities, applications, reporting and relationship management. It also creates barriers for long-term planning and staff retention. A fragmented funding model means that ECHs often rely on multiple funding streams. Reporting requirements are often extensive, they differ by funder and are typically not funded.
- **Insufficient funding:** Providers identified that funding was rarely sufficient to deliver anywhere near the range of holistic services required to meet community needs, with many citing inability to provide important services and/or significant wait lists for existing services. ECHs often face pressure to cut programs, reduce services or source partnered delivery services in order to stay within tight budgets. Insufficient funding was a particular challenge for ECEC provision, when operated by ECHs.
- **Restrictive grants:** Some grants were noted to be highly restrictive and could impact ECH providers' ability to appropriately allocate resources as well as third party providers' ability to provide partnered delivery services within the ECH. Restrictive grants can limit ECH providers' ability to allocate limited resources in a way that best meets community needs, while also ensuring the ongoing viability and sustainability of the ECH and ECH provider. ECHs also depend on the way partnered delivery service providers are funded for their work. If partnered delivery service providers are funded by grant/s that restrict them from offering services or participating in integration work within an ECH, it may be difficult for ECH providers to meet community needs where they rely on partnered delivery service provision.
- **Outside of more holistic state-based ECH funding models, government funding models rarely provide funding for glue:** Where ECH providers are unable to obtain dedicated glue funding, existing ECH staff were required to complete additional, but necessary work. This requirement creates a number of additional risks for the ECH, including key person risk and staff burnout. In relation to key person risk, where glue was unfunded, ECHs had less resourcing to establish and embed governance structures and in some cases, relied on key relationships to establish and integrate partnered delivery services. Should the person holding the relationships leave, there is a risk to the ongoing partnered delivery service provision and integration.
- **Funding rarely covers infrastructure maintenance and capital works:** Often operational funding is only sufficient to meet the direct operating costs of ECHs, resulting in insufficient funding for infrastructure maintenance and capital works. Grants or other funding sources for these requirements are rare. This can represent a significant impost on ECH finances as well as a risk to ongoing sustainability when these capital works become more urgent.

Challenges such as short-term, fragmented funding are brought to life through the quote below:

> *"As a leader in an Aboriginal Early Years Service, I've seen my role shift significantly — from leading pedagogy to being consumed by administration. The burden of reporting across multiple funding streams has become overwhelming. With up to eight different funding sources, each requiring separate, often quarterly reports — covering data, compliance, KPIs, budgets, and milestones — it's an immense administrative load. To remain viable, we must seek alternative funding beyond the mainstream Child Care Subsidy (CCS), which only supports standard placements and doesn't account for the culturally specific and holistic programs we provide in Aboriginal Early Years Services."*
>
> – Stacey Brown, Yappera Children's Service

While all ECHs consulted in this research are currently operational, their viability may be challenged by ongoing funding constraints. One provider noted that the closure of an ECH could result in not only the direct loss of services and supports, but also the loss of significant infrastructure and diminished trust that had been built with families over time.

6.1.4 Partnered delivery service provision

A commonality across many ECHs was the use of partnered delivery service provision. Leveraging partnered delivery service provision enables ECH providers to leverage external expertise to offer services that align to community needs with the ECH. These services may not be achievable within the ECH's funding arrangements and organisational expertise. Further, delivery by others already operating in the community optimises the existing funding in the service system and supports integration across the system. Premises are typically provided without rental charge to the service provider, with the service provider retaining ownership over their revenues and costs. Partnered delivery provision requires additional support from the ECH to ensure that these services are onboarded, values aligned, culturally safe and effectively integrated into the broader ECH operations to holistically and with minimal friction, provide ECH family participants the services they need. Onboarding and integration of services are usually glue functions, which highlights the importance of sufficient glue funding.

6.2 ECH cost components

6.2.1 Embedding the glue: Relational infrastructure for integration

Overview

- Across all ECHs, successful integration is underpinned by a distinct but often undervalued function of integration also known as the glue – the relationships, people, systems, and backbone support that hold services together with a shared purpose to reduce complexity for families, meet their needs and improve outcomes for children[15]. Importantly, the glue is multi-dimensional: it is not a single role or process, but a set of interconnected components tailored

[15] SVA, Sticking points: Why the 'glue' helps Early Childhood Hubs thrive, [online] available: https://www.socialventures.org.au/about/publications/sticking-points-why-the-glue-helps-early-childhood-hubs-thrive/.

to the unique needs of each community. For the purpose of financial modelling, the glue has been costed based on staffing costs for key integration roles (such as ECH coordinators, community connectors, and backbone support staff) that enable collaboration, coordination, relationship-building and governance as well as funding for glue operating expenses (such as travel and printing) included. Other glue components – including place-focused design – are critical but have not been separately costed due to lack of evidence. Where appropriate, ECHs should further consider incorporating these additional cost components to develop a more complete estimate of the total cost of the glue.

> *"One person within the organisation has to have a vision across all the areas where the hub is working, from education to health to social services. You have to have someone that can drive that unified approach to make sure it's all aligned."* – ECH provider

Within the ECH site, the staffing component of glue typically takes three main forms:

(a) a coordinator role (i.e. Partnership Managers or Integration Leads) focused on cross sector co-ordination across multiple service roles, governance, and operations, and
(b) a community engagement role (i.e. Community Facilitator) focussed on acting as the first point of contact, building relationships with families and outreach.
(c) an administrative role that may be located onsite or in a head office. Recognising the need for backbone/head office roles to support the operations of the ECH, this role may cover corporate professionals such as HR, administration, legal and/or finance. Subject to the needs and structure of the ECH provider, this role may be split across multiple part time/contractor professionals.

For the community engagement role, multiple ECHs highlighted the importance of hiring staff for these roles from the community as they can utilise their existing relationships, cultural knowledge and contribute to families feeling safe and welcomed into the ECH.

Community outreach and engagement is core work

Outreach was generally recognised as essential to ECH success due to its central role in bringing communities into the ECH and reaching families not accessing services and supports. In this context, outreach is defined as the activities undertaken by ECHs to connect with families and communities who may not otherwise engage with services. These could include building awareness and trust, reducing stigma associated with accessing services as well as pre-ECH establishment consultations and codesign processes. Several ECHs described extensive pre-establishment community consultation and co-design processes could be wide-ranging, involving a variety of stakeholders and taking over a year.

Providers also spoke about the importance of creating non-stigmatising entry points to the ECH such as community playgroups, casual afternoon teas and other community events. One ECH told us they had a "No wrong door" policy:

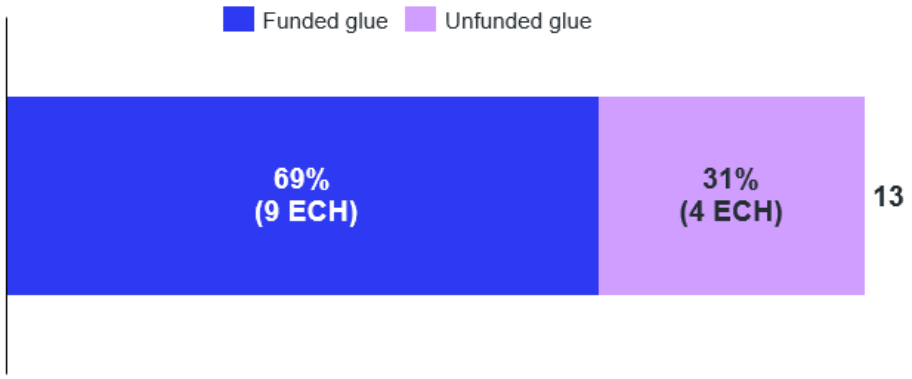
> *"We never want to turn anyone away. We support people to get the help they need and help them navigate those pathways."* - ECH provider

Outreach is generally considered a component of glue and typically funded within the glue funding. Support from service providers was sometimes sought to assist with outreach; however, this activity does not appear to be funded.

Given funding constraints, the relational nature of ECHs and the critical need to build trust, word of mouth was often the most powerful form of engagement. This was especially the case in culturally and linguistically diverse or tight-knit communities. Some ECHs that have operated for many years reported strong reputational capital, with families seeking support based on longstanding trust. In other contexts, stigma or misperceptions about ECH services required deliberate messaging to clarify that ECHs were universal, supportive spaces. This was particularly the case where there were assumptions that ECHs were associated with child protection services.

Among participating ECHs, 69% had dedicated glue funding, often through longer term philanthropic funding or within broader government funding models, which allowed them to have a defined glue function and dedicated glue staffing (see Figure 8 below).

Figure 8: Participating ECHs based on glue funding status



With this dedicated staffing, these ECHs were able to secure and integrate significantly more partnered delivery services, establish and operate strong governance structures and support higher levels of integration activity. **In fact, ECHs with funded glue offered on average 22 times more dollar value in partnered delivery services than that of the ECHs with unfunded glue** (see Figure 9 below).

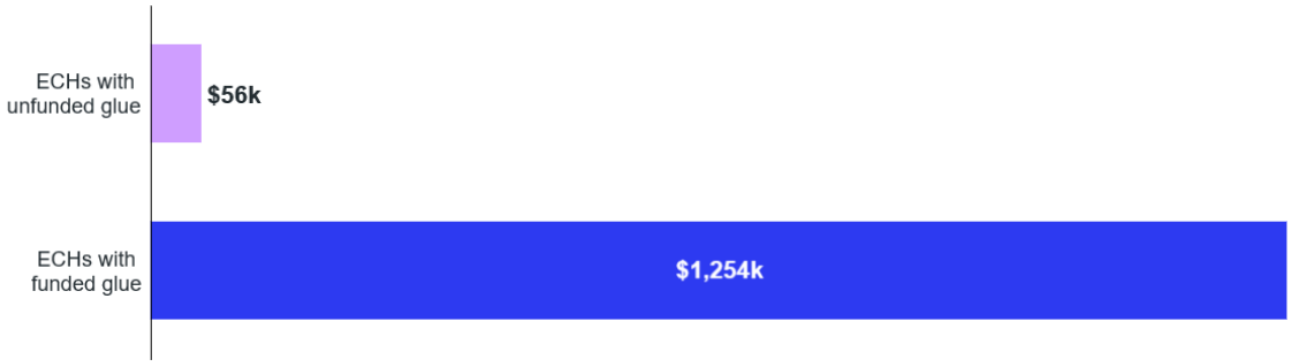
We note that where dedicated glue funding is provided, this often occurs concurrently with the establishment of a new ECH. A couple of ECHs with specifically allocated glue funding noted that they were able to implement pre-ECH establishment community engagement processes, and deliberate and considered governance processes, which supported the creation of an ECH that met community needs and had the necessary backbone infrastructure for ongoing sustainability.

In other ECHs without funded glue (31% of participating ECHs), these integration responsibilities were not as clear. Glue tasks were typically absorbed by existing staff in leadership roles, sometimes without dedicated time, support, or structural recognition. While this can be effective, it can also lead to burnout and role ambiguity, particularly when glue or integration work is seen as an add-on rather than a core function. Several interviewees noted that their integration work emerged through necessity.

One of the significant responsibilities of glue was the pivotal role it plays in brokering and integrating partnered delivery service provision. This distinction was clear when analysing the attributed cost of partnered delivery services at ECHs with funded glue vs unfunded glue. As noted, ECHs with funded glue had on average 22 times more dollar value in partnered delivery services than that of the ECHs with unfunded glue, as seen in Figure 9 below. Services such as LDC as well as allied health and medicine can represent a significant cost if provided in house. When funded glue is able to broker and integrate partnered delivery provision of these services, the impact on annual ECH operating costs is significant.

ECH providers shared how integration is essential to providing wraparound support. As one leader told us for example, *"Walk-ins can be given the support they need straight away"*.

Figure 9: ECH services partnered delivery value based on whether ECH has dedicated glue funding



Providers also highlighted that glue work is not limited to service coordination and relationship-building. It can involve a wide range of often invisible operational and logistical tasks such as negotiating legal agreements, navigating stakeholder requirements, coordinating governance or resolving practical issues such as shared infrastructure responsibilities or service duplication. These responsibilities reflect the complex infrastructure of integration – the behind-the-scenes coordination that makes collaboration effective and sustainable.

Challenges

Challenges more frequently emerged where glue was unfunded, limiting the ability of ECHs to deliver on integration and sustainability. Key challenges include:

- **Governance:** Where glue was unfunded, the level of governance was often insufficient and led to integration challenges, although some ECH providers were able to navigate this (see further section 6.2.2 below).
- **Outreach:** ECHs without funded glue had reduced capacity to conduct tailored and consistent outreach and more typically relied on word of mouth and/or leveraging existing community events. We expect that these limitations would be more pronounced during the establishment

phase of a new ECH given the criticality of community engagement, outreach and codesign processes during this phase. However, given that all ECHs with unfunded glue have operated for many years, and having evolved from community embedded organisations, this was not further investigated as part of this research.

- **Key person risk**: Without funded glue, responsibilities often defaulted to individual leaders, with roles evolving with their tenure. In these cases, ECHs are susceptible to the risk of these individuals leaving, as the sustainability of ECH relationships and partnered delivery services provision, in some cases, rely on individual relationships.
- **Limited capacity to manage partnered delivery arrangements**: With partnered delivery service provision central to many ECHs, the need for glue to broker, manage and integrate partnerships is heightened. ECHs with funded glue can manage and integrate significantly more partnered delivery services (up to 22 times more by dollar value) than those without.
- **Constrained transition pathways for community embedded services**: Existing community providers often lack pathways or access to glue funding. This can make it difficult to evolve into an integrated ECH model. This is unfortunate, noting that ECHs that have evolved from single service providers represent a place based, trusted and targeted response to specific community needs.
- **Leadership:** The critical role of leadership which is broadly defined and can include ECH leaders, service providers, government and school leaders (where co-located with a school) is key to setting the tone and expectations around integration. Even with funded glue, if leadership changes caused a reduction in support for integration, this would present significant challenges to glue integration work and ECH holistic service provision.
- **Location requirements**: when located within a school there can be challenges balancing community openness and a “doors always open” approach with operational risks of integration in a school context (i.e. safety concerns, visitor management and competing policy frameworks). Glue staff are necessary to support navigation of these barriers.
- **Head office expenses:** These represent the necessary support to run an ECH and include support roles such as HR, finance and administration. ECHs face challenges in funding these costs, especially those that operate on a standalone basis or are unable to leverage back office capability from a larger parent organisation.

> *“Staff act as cheerleaders and supporters, if they can’t do it they’ll give a warm referral – they don’t leave you hanging”*- Family member[16]

6.2.2 ECH governance

ECHs have complex and integrated operating environments. As such, effective governance structures and ongoing governance operations are critical to ensure accountability, integration and strategic alignment across services while also supporting ongoing ECH sustainability. A key finding from this research is that where glue is specifically funded, this targeted resourcing allows greater focus to be applied to the establishment and ongoing operation of formal governance processes.

We acknowledge that some ECH providers without specific glue funding have been able to implement governance processes, however this comes at the cost of other service delivery or staff

[16] The Australian Centre for Social Innovation. *In their words: Family perspectives on the power of Early Childhood Hubs* [Report], Social Ventures Australia, November 2025.

working additional hours. In the absence of glue funding, ECH governance structures were reported less frequently and relied on key individuals to navigate integration efforts. While this approach can still be effective, the lack of supporting infrastructure, such as formal governance, data sharing protocols and IT systems, makes the process time consuming and deeply reliant on individual relationships.

ECHs with funded glue, reported both community engagement and service engagement as key considerations in their governance structures. These are explored further below. Several ECHs also cited the need for leadership within the organisation – and at the organisations the ECH collaborated with – to be on board with the project of integration.

> *"Our CEO at the time we set up had a strong belief that education, especially early education, was integral to getting [children] on the right track to achieving their potential,"* said one ECH provider

Community engagement

Incorporating broader community participation into governance processes is a key approach used by many ECHs. ECHs actively seek to engage a wide spectrum of stakeholders from within their communities. These stakeholders commonly include service providers, government departments, schools (where located on a school site), parents, and cultural groups. By engaging diverse groups, ECHs strengthen their capacity to meet immediate community needs while driving broader systemic change.

Community engagement can occur at multiple levels and serve a variety of objectives. For example, stakeholders may contribute to shaping strategic direction, resolving systemic barriers to service delivery, or ensuring that services continually adapt to evolving community needs. Additionally, engagement provides opportunities for stakeholders to share knowledge and raise questions with other members of the community.

To facilitate these outcomes, ECHs may participate in existing community or stakeholder meetings, as well as establishing new governance groups dedicated to specific objectives. This flexible approach allows ECH providers to remain responsive to community needs while also maintaining strong links with a wide range of local stakeholders.

Service provider engagement

Certain ECH providers use service-led governance processes in which ECH coordination is overseen by an ECH manager or team leader. Program feedback and recommendations are provided by managers of various services, enabling ECH leaders to refine and enhance service offerings while addressing emerging issues promptly. Such governance structures may apply to services delivered both internally and through partnered delivery arrangements.

ECH providers undertake a deliberate approach to incorporating the engagement and ongoing lifecycle management of partnered delivery service providers in formal governance processes, ensuring that ECH service integration objectives continued to be met. This structured engagement could incorporate initial legal agreements that ensure third party partnered delivery providers are

aware of and comfortable with ECH operating expectations including integration, in some cases supported by training and induction processes for new partnered delivery service providers. Lifecycle governance processes could also be used to ensure the ongoing effectiveness of integration, ranging from formal commitments to regular meetings and the sharing of practices.

By doing so, ECHs maintain a strong focus on collaboration, accountability, and alignment of services across multiple partnered delivery service providers. The structured involvement of partnered delivery service providers facilitates ongoing communication, shared goals, and mutual understanding, all of which contribute to effective integrated service delivery for the community.

Key challenges

- **Lack of dedicated glue funding:** ECH providers without dedicated glue funding face challenges in establishing and operating the governance structures and processes necessary to support a sustainable and integrated ECH. These ECHs at times rely on relationships which are time consuming to establish and maintain in the absence of formal structures, which can lead to key person and continuity risks.
- **Service capacity:** effective governance processes rely on service providers having sufficient time to engage meaningfully in these processes and with community members. Variance in service providers' operating hours and limited staff capacity present challenges to governance implementation.
- **Embracing the voice of community:** formal provision of feedback can be difficult for families who are often overwhelmed by highly challenging circumstances. In this case, incorporation of community feedback within governance processes relies on service providers having sufficient time and appropriate channels to respectfully obtain this feedback.
- **Regulatory requirements:** irrespective of the quality of governance processes, services whether provided in house or via partnered delivery such as health and education, face significant and complex regulatory requirements around access, data sharing and privacy that may limit the scope of integration.

6.2.3 Service provision

Services overview

ECHs are intended to provide integrated, wraparound services tailored to the needs of families and children in their communities. ECH providers spoke of the value of integrated supports and service alignment, enabling warm referrals between services, ability to identify and address early intervention requirements and enabling children and families to have their needs met without requiring them to repeat their story. In this context, ECHs represent a unique operating environment that requires service staff to work within an unfamiliar environment. ECHs represent a multidisciplinary and highly collaborative approach between health, education and social services to support families in an integrated manner. This is a significant change to typical ways of working, noting that these service systems have usually operated independently and are subject to different and significant regulatory requirements and operating procedures. Staff are also required to collaborate closely with a broad range of other service providers (if applicable) with different employers operating within the ECH.

ECH service provision explainer: in-house vs partnered delivery

Two main models of ECH service provision were identified within this research, inhouse and partnered delivery, with many ECHs utilising a combination of both types of service provision (noted as a third hybrid model).

1) In-house service provision relates to services provided by employees/contractors of the ECH.
2) Partnered delivery service provision refers to services provided within ECH premises, typically without direct financial cost to the ECH or families. The types of services, nature of arrangements and length of arrangements varied significantly between ECH providers and could be a long-term systemic relocation of services governed by formal arrangements or be more reflective of a pro-bono and shorter-term arrangements.

It is noted that ECH providers often leverage service provision from both inhouse and partnered delivery service providers as a response to practical requirements including service availability in the community, ability to relocate in community service provision into the ECH, and limitations of ECH budgets.

Overall partnered delivery provision is the preferred cost-effective model, consolidating existing quality services within a safe and trusted setting to provide seamless supports for children and families. It enhances efficiency and effectiveness of government (and non-government) service delivery and avoids duplication. However, it is not always feasible. It is preferred when two key factors occur:

1) Quality services are available in the community and have the flexibility to be able to offer services within or nearby the ECH for an integrated service offering.
2) the services are values aligned and support the integrated ECH culture.

Partnered delivery models with multiple different service providers requires adequate glue resourcing and bespoke governance arrangements to ensure a smooth and integrated service proposition to the community.

In-house provision is a preferred or practical response when these factors are occurring.

1) Services are otherwise unable to be offered in the ECH or nearby in a way that meets ECH family needs. This may be due to unavailability of services in the community, services available in community but unable to be relocated to or near the ECH or unable to be provided in a way that meets the needs of ECH family participants.
2) The ECH provider has the relevant specialised expertise (for example, is also an ECEC provider or a provider of family support services) or can source this to provide inhouse, to provide quality services with the necessary experience and regulatory oversight.

Models with in-house service provision also require sufficient glue funding, albeit different aspects of glue may be required. Even with a single employer, there are complexities in integrating a diverse service offering (i.e. health and education) to offer families a holistic service provision. While not fully investigated by the project, a greater level of inhouse service provision is expected to require a greater level of corporate services staffing, given the complexity of employing a broad range of staff (i.e. health and education and the varied regulatory requirements), noting that there are other drivers for this, such as ability to leverage capabilities from a parent organisation. During

consultations it was observed that ECH providers who employed across a broader range of staff roles tended to be part of larger parent organisations.

The need for a site-based community engagement glue role is necessary irrespective of service provision model.

It is noted that partnered delivery services including integrated health, social services and education service provision, represents a significant shift in the way that these services are typically provided. With respect to instances where services are available in the community but in-house provision is preferred, this is in recognition of the need for a short term and practical response to current community needs. In the long term, the preference would be that barriers limiting the fit for purpose provision of these services within an ECH are removed and these are generally provided as partnered delivery – acknowledging that generally an ECH is also an ECEC or more broadly early learning provider and/or school, which provides the "front door". This will allow more seamless provision of child and family centred services and supports to communities experiencing significant socioeconomic disadvantage, as part of a joined-up child and family system.

In terms of services offered within ECHs, common services include playgroups, parenting support, maternal and child health (MCH), food relief, home visiting, family support and allied health. ECHs seek to add allied health and support services in response to waitlists and community needs, reflecting strong demand and a commitment to holistic child support. To effectively manage limited ECH budgets and enable the breadth of services provided, ECH providers utilise partnered delivery services and in-house service provision, where they seek funding (often grants), for staff to provide specific services. Level and breadth of service provision, particularly partnered delivery was linked with access to glue funding. The reason for this is that the development of relationships with various service providers, as well as the integration and coordination of these services was often primarily the responsibility of glue roles.

ECH providers had a strong focus on encouraging families across the community to access the ECH. ECH providers utilised various approaches to remove barriers to attendance including soft entry points such as informal spaces to share a hot drink and food pantries. These soft entry points allow staff to build trust and observe early signs of vulnerability whilst supporting families to build comfort in engaging more broadly with ECH services. ECH providers also offered free, low-barrier service access points (e.g., community engagement activities, playgroups, parenting programs). Essentially, these services support ECHs in remaining accessible and non-stigmatising.

> *"We offer hats, sunscreen, food... we're trying to remove any barriers at all. And it has to be free – even a gold coin [charge] is a barrier*." - ECH provider

Another key element of service provision across ECHs that was observed was agility and flexibility, which unfortunately in some cases appeared to be a necessary response for ongoing operations in a cost constrained and uncertain funding environment. Service provision is adjusted, both in response to limited funding availability, but also to meet changing community needs. Cost and availability of specialist staff is also a consideration within the service offering. Services are regularly reviewed including via governance processes where applicable, using a combination of community consultation, attendance data and informal feedback, which allows ECHs to pivot in response to

emerging needs. For example, several ECHs noted an emerging or increasing need for food relief (e.g. Community food pantries).

All ECH providers emphasised quality and the need for appropriate levels of quality staff in order to undertake their work. Providers noted the ongoing challenges of talent shortage and high turnover, particularly in the ECEC sector. For ECHs that were able to retain high-quality staff, they noted that these not only supported operations but also helped staff to form positive connections with families and children.

> *"We pay above award here,"* said one ECH provider. "*We recognise what our staff bring."*

Another provider highlighted the need for staff to be willing to work in a multidisciplinary team and respect the different "lenses" (e.g. a health lens vs an education lens).

> *"It's a challenge to get the right fit,"* they acknowledged. *"When we interview, we look at team fit. Is this person going to fit in with the team and what are they bringing to the team?"* They described creating the right team *"an ongoing process of negotiation"* which required making a safe space to ask questions and challenge perspectives. *"When staff are the right fit, they thrive and never want to leave."* - ECH provider

Service challenges

This research identified several key challenges in relation to provision of non-ECEC services.

- **Staff shortages and cost**: ECH participating families may have higher vulnerability and complex requirements, and the ECH operating environment which integrates health, education and social services represents a different way of working. This may necessitate a requirement for more experienced staff against a backdrop of staff shortages and competition with the private sector. To attract and retain appropriate staffing, ECH providers identified a need to pay above award wages, presenting a challenge to breakeven financials.
- **Capacity constraints**: In many cases ECH providers noted that demand for services significantly exceeded what they were able to provide with available funding and partnered delivery, with ECH providers citing long waitlists for certain services, limited availability of certain health professionals to address community needs or the need to cancel services that, while operating below capacity, addressed key needs for participating families. This was often driven by insufficient funding to address community needs.

> *"We are majorly limited by funding… Our waitlist for our family support program is six months. The need is so large. It wears you down as a worker to turn people away."* - ECH provider

- **Reliance on partnered delivery provision**: Many ECHs rely heavily on partnered delivery service from external providers (e.g., allied health). While this can reduce direct costs of running these services and efficiently coordinate and optimise existing resources within

communities, multiple service providers can create challenges in offering an integrated service proposition to the community, which in turn requires sufficient glue resourcing and governance processes to manage. Additionally, reliance on partnered delivery service provision means that if services are unavailable in the community, unable to be relocated or not appropriate or safe for the community, the ECH will not be able to offer this service.

- **Allied health**: Many ECH providers observed that demand for allied health often exceeds available provision, with long waitlists or reliance on external referrals.
- **Integration constraints when glue is unfunded**: In ECHs without glue funding, there exists limited capacity to broker or manage partnerships across partnered delivery service providers. This can significantly limit the ECHs ability to procure necessary services as well as lead to fragmented delivery or siloed services that struggle to meet the needs of attending families and can therefore limit the impact that the ECH is able to have. This may also reflect limited capacity to consider different structures and ways of working.

ECEC overview

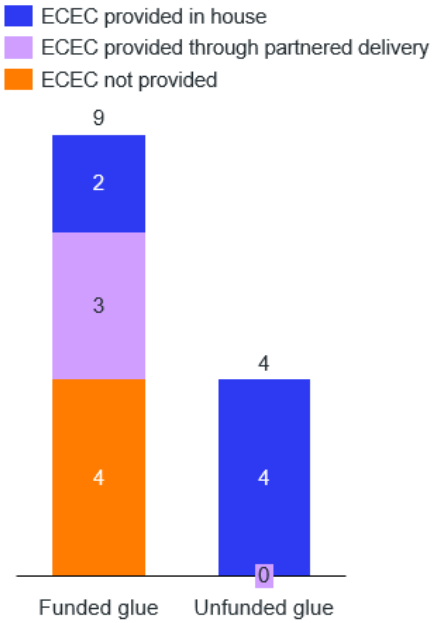
ECEC includes long day care and/or pre-school services. Early learning is a broader term including ECEC as well as playgroups and other informal models, like Toy Libraries. We've separated ECEC from playgroups given their distinct funding models, with LDC and preschool funded by Federal and state and territory governments respectively.

Early learning is a critical component of ECHs. Early learning supports ECHs to provide a birth to school offering, enable early intervention, strengthen children's learning and development, improve school transitions and contribute to the delivery of holistic support to children and families. It also provides a positive front door for families, focused on partnering to support strong outcomes for their children.

Providers with ECEC integrated into ECH operations highlighted several educational and developmental advantages such as supporting staff to identify developmental delays earlier and coordinate sensitive and timely interventions. It was also noted that integration of ECEC into ECHs supports ECH staff to encourage families to enrol their child in ECEC, whereas without a warm introduction and co-located service, the child may otherwise not attend. While challenges around cost, integration and compliance with regulatory obligations were noted, the perceived value of ECEC inclusion was typically strong

Where provided, ECEC service provision within ECHs takes different forms. Some ECHs operate ECEC services directly, while others rely on partnered delivery provision from external providers, others link to nearby schools, and some may not have scope for provision. A breakdown of ECEC provisions within ECHs can be seen in Figure10 below. For those ECH providers directly operating services, ECEC is often loss-making due to revenues being below delivery costs. This is a characteristic of lower socioeconomic areas where providers are limited in the fees they can charge, and higher staff ratios and more experienced staff may be required to meet the needs of attending children. ECHs with ECEC provided in house may face greater viability risk than those without as ECEC services typically require cross-subsidisation from other revenue sources or ECH staffing. For the four ECH providers without funded glue as noted below, ECEC was provided as a core service, with providers seeking to offer additional services in response to community need. For ECH providers where ECEC services were provided as partnered delivery, the project was unable to access the information pertaining to their revenues and costs.

Figure 10: ECEC service provision within participating ECHs, based on glue funding status



ECH providers generally identified various benefits from offering ECEC, and despite challenges noted above still sought to offer these services.

Playgroups

Playgroups represent a broad range of offerings, from volunteer run to co-led by early childhood educators and allied health professionals, with a specific program design that supports children with potential developmental challenges. These playgroups can offer a range of benefits including 'soft entry' to ECHs whilst also providing early learning and targeted early intervention support. Nearly all ECHs consulted with offered playgroups with many providing multiple playgroups, some focussed on specific community needs.

> *"In order to be viable, we have to explore different funding options outside [government funding]."* - ECH provider

ECEC challenges

Challenges around ECEC service provision within ECHs emerged consistently and supported findings from the literature review.

- **Financial sustainability** was seen as a prevalent central issue, with ECEC (if run inhouse) typically requiring cross-subsidisation from other revenue sources or staff. In communities experiencing socioeconomic disadvantage, limited fee-paying capacity and the need for higher staff-to-child ratios and more experienced staff contribute to elevated operating costs. For the few ECH providers where the activity test was discussed, this removal was not

perceived to be able to support LDC profitability. This was driven by various reasons, including ineligibility for subsidy (i.e. refugees), higher acuity children gaining access (with insufficient inclusion funding) and government settings supporting a shift to preschool and work from home arrangements leading to children kept at home.

- **Overly burdensome compliance requirements.** While important to ensure safe operation of ECECs, some compliance requirements were identified as overly burdensome and a significant challenge and barrier to operating within an ECH context.
- **Integration of ECEC** as a service line into the broader ECH was noted as particularly challenging for various reasons. In some cases, ECEC staff were seen to have less flexibility to engage with broader ECH governance and integration processes, due to the operating hours of the ECEC and limited ability for staff to leave during operating hours to engage with broader ECH activities.

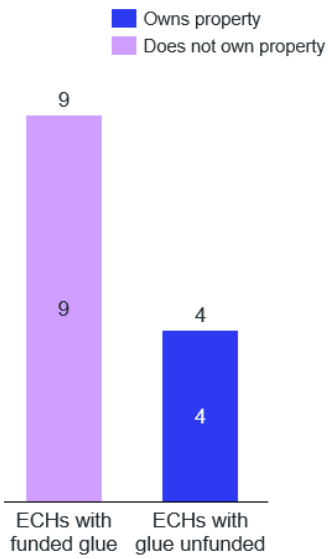
6.2.4 Infrastructure

Infrastructure plays a critical role in shaping how ECHs operate and how accessible and integrated they are for families.

Overview

Infrastructure is a critical enabler of ECH operations but also a major constraint where costs are not absorbed by government. Most ECHs operate in facilities owned or managed by State and Territory government departments, often with no or minimal rental costs and longer leases which provide the security and continuity. Others operate out of facilities that they own, which may provide a level of stability but also expose ECHs to significant maintenance and repair costs that place pressure on already tight budgets, and can risk ongoing viability. Where the building is owned by the ECH provider, use may be subject to broader organisation and business priorities. Typically, ECHs with funded glue have property provided in-kind, whereas those without funded glue own the property. This breakdown can be seen in Figure 11 below. Across the board, provision of infrastructure at no or low cost (e.g., peppercorn rent) is generally assumed in current funding models and is essential for ECH viability.

Figure 11: Property ownership based on ECH glue funding status



In terms of the facilities themselves, a consistent theme was the importance of purpose-built ECHs. These ECHs feature intentional and inclusive design elements such as multipurpose community rooms (for playgroups, adult education and parenting groups), private consulting rooms, informal community gathering areas, early learning spaces (indoor and outdoor) and single front door entry points. These purpose-built ECHs were important in fostering integration through their ability to incorporate community requirements, meet the needs of individual services and create space to facilitate service delivery integration. This design is important to meet the needs of holistic service provision (from medical appointments, informal community gathering and educational play), while also having an intentional floor plan design that helps foster informal connections between early educators, health workers and family support teams. Other examples include the use of multipurpose rooms allowing for flexibility in program delivery while supporting a welcoming and non-clinical environment, as well as careful consideration of indoor and outdoor spaces which can help to ensure that programs can be delivered, regardless of weather. Although these may appear to be small decisions, their intention can be the key to building trust and relationships with the community, which essentially supports broader engagement with the ECH.

ECHs that are purpose built are more common in new builds/greenfield developments, however in some cases they may also be feasible in retrofit scenarios. Retrofitted sites can achieve similar outcomes but are typically more costly and subject to the extent of the retrofit, can be less effective in supporting integration and meeting needs for service delivery. Participating ECHs operating out of converted spaces highlighted their spatial and functional limitations. Providers noted lack of privacy in shared spaces, or inability to expand due to zoning or building constraints.

> *"Consulting rooms would support us to be a one-stop-shop for families, which would improve families' engagement with these services. But the block we're on limits our opportunities to expand."* - ECH provider

It is important to note that the physical design of infrastructure alone is not sufficient. Effective use of infrastructure requires complementary ways of working, such as allocating dedicated time for integration work, joint planning and co-facilitation across services. Location of infrastructure is also key; locating and integrating ECHs within schools was a theme that emerged throughout the research process, supporting ECH objectives of a smooth transition into formal education, enabling convenience for families and in some cases allowing some ECH services to support the broader community. Our consultations indicated that when ECHs were located within schools, rent was typically not charged. However, responsibility for costs such as cleaning and staff amenities varied, and could be subject to significant negotiation.

Maintenance costs vary significantly between ECHs. Some costs are absorbed by the infrastructure provider, while in other cases ECHs funded these directly. Some participating ECH providers struggled to find the funds to maintain their buildings, which were "old and inadequate". Few providers had access to the capital needed to make modifications where needed, even just to keep pace with necessary repairs. The nature of high capital and rental costs mean that, without infrastructure provision at no cost, there exists a significant barrier to establishing an ECH.

Figure 12: Infrastructure costs and cost drivers based on ECH glue funding status

Infrastructure cost drivers (average, #)

Drivers	Funded glue ECHs	Unfunded glue ECHs
Total glue space (sqm)	80.8	13.1
Total Service space (sqm)	1314.1	1601.4

Overarching Infrastructure costs, (average, $k)

Cost items	Funded glue ECHs	Unfunded glue ECHs
Infrastructure	11,155	12,916
Infrastructure (maintenance)	446	517

Challenges

There were consistent challenges that emerged around infrastructure, particularly where infrastructure was not provided in -kind. These included:

- **High operating costs:** Maintenance, cleaning, and repair expenses can overwhelm already tight ECH budgets (estimated average annual maintenance cost of ~$468k) when not covered through in-kind cost arrangements.
- **Rising costs:** Rising award wages and maintenance costs present challenges to ECH cost management, whilst higher costs of living lead to increased community need and greater demand for ECH support.
- **Fit-for-purpose limitations:** Providers operating in facilities not custom-designed for ECHs face constraints such as limited capacity for ECEC or an inability to offer certain services. Workarounds are common across ECHs, but these can often place additional burden on staff.
- **Retrofitted buildings:** Retrofitted facilities are often more costly and complex to adapt than greenfield builds, with issues including existing building characteristics and compliance with building regulations. Ensuring ECH infrastructure meets community demand is particularly challenging in these contexts.
- **Parent organisation constraints:** ECHs embedded in parent organisations can sometimes experience challenges around having less control over the use of buildings, which may be subject to broader organisational priorities. This setup can also create financial challenges, noting the ECH provider has responsibility for maintenance, renovations or capital upgrades.

7. Funding model requirements

7.1 ECH Income and contribution requirements

Overarching income requirements

Sustainable and viable ECH provision requires long-term and stable funding, primarily from government, that covers full cost of delivery and reduces reliance on short-term grants or fragmented income streams. Optimising an ECHs response to community needs requires flexible funding, including ability to shift funding where services become available (and can be provided through partnered delivery) or when community needs evolve. The funding also needs to recognize the full costs of operating an ECH and provide adequate coverage of the indirect costs associated with service provision such as IT and maintenance, recognising these needs will vary between different ECH provider structures from standalone single ECH providers to larger non-government organisations.

One ECH provider emphasises that running a high-quality service required investment in governance, staffing and professional development, but also allocation for essential community needs such as free or affordable meal provision for children attending ECEC services.

> *"We can't do what we do without investment. We could get rid of all of this to save money and just do the bare minimum... but we want the best for our children."* - ECH provider

To optimise ECH staff time in service delivery, funding processes should be designed with streamlined application and reporting processes to minimise impost on ECH providers or need to source specialist grant expertise.

In relation to ACCO's specifically, a specific funding mechanism is needed for integrated service provision, as well as to support mechanisms to grow and sustain the ACCO early years sector.

Effective and sufficient funding model features will allow ECHs to meet children, family and community needs and support ongoing viability and sustainability for ECHs at greater scale across Australia.

Overarching contribution requirements to support partnered delivery service provision

Use of partnered delivery service provision can reduce duplication and provide families access to integrated services within a safe and welcoming environment. To maximise ECH utilisation of partnered delivery services where appropriate, cross collaboration is important to remove barriers to partnered delivery service provision within integrated ECH models to achieve higher community participation. Barriers can involve limitations on service providers relocating their services to an ECH or not being able to participate in ECH integration activities.

Funding is key, but true community impact comes from integration at every level

To ensure integration is a core feature of ECHs, it must be embedded as standard practice across every layer of the system – not just through funding, but through policy, governance, practice, and community design. At the policy level, integration needs to be recognised as essential infrastructure within all policy reforms, with aligned objectives and accountability across education, health, and family services. At the governance level, cross-sector structures should bring together funders, providers, and communities so planning and accountability are shared, not siloed. On the ground, integration happens through the work of staff who coordinate referrals, link families across services, support sharing of different professional lenses and build trusted relationships – roles that need to be explicitly recognised and resourced rather than left to goodwill. Importantly at this level, integration must be community-led: families should shape how ECHs operate, bringing lived experience, deep knowledge of community needs, and cultural knowledge to ensure services are responsive to local needs,[17]

7.2 ECH cost analysis

7.2.1 ECH costing using the building blocks model

As indicated earlier in this report, ECH models are usually customised to meet specific community needs. Factors such as size of the population being served, socioeconomic conditions, access to services, infrastructure availability and geographic location all play a significant role in determining the ECH service model. In this part of the report, we use the building blocks model to provide indicative costing for three different ECH service models. All three service models assume an onsite funded glue function as well as a FTE allowance for head office staff cost and other services being provided either through partnered delivery, hybrid or in-house, namely:

- **Partnered delivery model:** relies on glue to procure and integrate ECH services with services provided at no additional financial cost to the ECH or participating families. This can involve relocating services already provided elsewhere in the community to within the ECH. The model is preferred, unlocking and optimising existing funding, but relies on these services being available in the community, and able to be relocated to and integrated within the ECH.
- **Hybrid model:** employs staff to deliver core services that are not sufficiently available or inaccessible in the community for ECH family participants, while relying mainly on partnered delivery methods for other community needs.
- **In-house model** allows for a level of staffing to provide all core and desired services.

Indicative costs are presented as a unit price of a specific cost category for an ECH based in metro NSW, providing services to a community of 100 families, which includes an estimated 200 children l, and has a 60 place ECEC centre. This size was adopted as an average sized hub. The building blocks model provides the ability to scale up or down the unit costs, i.e. to introduce additional rooms or services to meet specific community needs and specific service requirements.

Costs are presented as a multiple of a designated unit price for each costing category. Figure 13 details units and prices that were used for the identified costing categories:

[17] SVA, "Sticking points: why the ''glue'' helps Early Childhood Hubs thrive', SVA online [https://www.socialventures.org.au/about/publications/sticking-points-why-the-glue-helps-early-childhood-hubs-thrive/]

Figure 13: Unit costing categories[18]

Cost category		Cost unit	Total personnel cost		Partnered delivery model multiple	Hybrid model multiple	In-house model multiple
			Salary & Super	On cost loading (25%)			
Glue		1 FTE Coordinator 1 FTE Comm. Engag't 1 FTE Admin	$157k $103k $82k	$39k $26k $21k	1 2 1	1 2 1	1 2 1
Services	Early learning	1 FTE Educator 1 FTE Social Worker	$79k $77k	$20k $19k	0 0	0.5 0.5	0.5 0.5
	ECEC	1 FTE Centre Director 1 FTE Educator 1 FTE Early Childhood Teacher	$115k $79k $108k	$29k $20k $27k	0 0 0	0 0 0	1 7.8 1
	Maternal & Child Health	1 FTE Nurse	$92k	$23k	0	0	3
	Family Support Services	1 FTE Social Worker	$77k	$19k	0	4	4
	Community des. activities	1 FTE Allied Health Prof 1 Resource (estimate)	$109k $20k	$27k -	0 0	0 0	2 1
	Allied Health & Medicine	1 FTE Allied Health Prof	$109k	$27k	0	1	1
Infrastructure	Consult Room	1 room (39.3m^2)	$314k		1	1	1
	Meeting/Community Rooms	1 room (91.7m^2)	$734k		1	1	1
	Informal space	1 room (40.5m^2)	$324k		1	1	1
	Play environment	1 room (91.7m^2)	$734k		0	1	1
	ECEC space	900m^2	$7,200k		0	0	1
	Fixtures	estimate	$20k		1	1	1
Rent		6% of build			1	1	1
Maintenance		4% of build			1	1	1
Other ECH costs		estimate	$100k		1	1	1

Staff unit prices are based on award rates, job advertisements and feedback from ECH providers during the consultation process. Staff costs noted above include salary and superannuation. For specific roles where ECH providers have indicated above award salaries are required, this has also been incorporated. These roles are, in particular, educator roles, and above award wages are considered necessary to support recruitment and retention of staff with appropriate experience to support quality ECEC provision and to better cater for higher proportions of children with complex needs. Further detail is provided in Appendix B.

The unit cost for community designated services has been calculated to 1 FTE health professional recognising that this was a common request for ECH providers. We have also included an estimate allowance for resources or activities. ECH providers can utilise the relevant number of units of this to fund other common priorities such as to hold cultural events/workshops, establish and resource food support, or to fund transport related costs.

Figure 14 provides costings outputs for the three ECH models using the building blocks model and metro NSW unit prices. The figure indicates in blue the first year of operating costs (glue, services staffing, rent, maintenance and other). It also provides infrastructure build costs (excluding land).

[18] Unit costs have been derived for various sources including feedback from ECH providers, feedback from the wider early years sector and publicly available data including award rates, job advertisements and room measurements.

Figure 14: Unit price costings of three archetypes of ECH models which serve 100 families, including up to 200 children, and has a 60 place ECEC in metro NSW.

Indicative costing for an ECH which serves 100 families and has a 60 place ECEC

Cost category	Service provision	Service model		
		Partnered Delivery	Hybrid	In-house
Glue p.a.	Glue	$0.56m	$0.56m	$0.56m
Services (ECH staffing) p.a.	Early Learning		$0.10m	$0.10m
	ECEC			$1.05m
	Maternal & Child Health			$0.35m
	Family Support Services		$0.38m	$0.38m
	Community designated activities			$0.29m
	Allied Health & Medicine		$0.14m	$0.14m
Infrastructure p.a	Rent	$0.08m	$0.13m	$0.56m
	Maintenance	$0.06m	$0.09m	$0.37m
Other p.a	Other ECH operating costs	$0.10m	$0.10m	$0.10m
Total ECH operating cost p.a.		$0.80m	$1.49m	$3.90m
Initial Infrastructure (initial outlay for build)	Consult rooms	$0.31m	$0.31m	$0.31m
	Meeting / community rooms	$0.73m	$0.73m	$0.73m
	Informal space	$0.32m	$0.32m	$0.32m
	Play environment		$0.73m	$0.73m
	ECEC space			$7.20m
	Fixtures	$0.02m	$0.02m	$0.02m
Total ECH build cost		$1.39m	$2.13m	$9.33m

It is evident that costings vary significantly between the service models. This demonstrates the level of flexibility that is needed in ECH funding models to meet the varying needs of communities and to provide access to required services and appropriate infrastructure to support community needs. We also note that costs will vary between different states as well as metro, regional and rural contexts, driven by a variety of factors beyond community need and available service provision in community. This can include workforce availability, transport requirements and cost of materials. ECH providers will need to adjust the unit costs noted in Figure 13 to reflect the features of their community. This project has not pursued location-based loadings, recognising the significant variability in communities across Australia. While these numbers may appear high, many of these services are already funded within existing government service systems or represent a basic entitlement that should already be funded within the community.

The model includes the cost of glue staff and operating expenses, as well as cost of infrastructure. It does not include direct costs associated with partnered delivery service provision with the assumption that ECH providers will leverage unlock existing investment within the system. Partnered delivery allows integration of a broader range of services within an ECH and supports broader cross

system integration. This enhances its ability to address community needs and improves cost effectiveness.

In the three ECH models discussed in this paper, a standard cost of glue has been adopted, recognising the instrumental role that glue plays in providing a genuinely integrated ECH. Glue has been contemplated as three key glue roles, two site-based as well as an administrative role. Site-based glue costs two different roles, a coordinator role and a community engagement role. These costings are based on average role costs of ECH providers with funded glue and are inclusive of salary, superannuation and loading for on costs. Average ECH provider costs are derived from either actuals provided by the ECH or assumptions made based on award data. The costs are calculated as FY26 figures, with award indexation and inflation rate utilised to calculate these numbers.

One FTE administrative role is included recognising that this role is a critical enabler of ECH integration across a diverse and complex range of service provision, irrespective of service model (in-house or partnered delivery). This funding category is an approximate FTE to cover the cost of multiple services delivered on a part-time basis, such as HR, payroll, legal and administration, recognising the incremental requirements for corporate support an ECH will have. ECH providers may flexibly allocate this FTE across various staff/contractor roles to meet requirements and add up to 1 FTE. The specific type/s of administrative roles and head office costs funding required will vary between services. This is in part dependant on whether the ECH is able to leverage back-office operations of a larger parent organisation, and whether the ECH provider has multiple sites or is operating as a single ECH on a standalone basis. The funding of glue must also include the indirect head office costs necessary for ECH provision.

For ECH providers it is noted that the unit cost model allows for higher/lower loading (multiple) of units depending on number of children and families being serviced, availability and complexity of service and geography.

7.2.2 ECH model outputs and costing analysis

This section outlines the associated costing analysis as follows:

Partnered delivery model costing: This model assumes that there is an uninterrupted access to adequate services, and all services are provided through partnered delivery. Total **operating cost per annum of $0.80m** incorporates:

- **$0.56m p.a. ongoing glue cost.** These are wages and superannuation paid to one ECH Coordinator, two Community Engagement Officers, and one administration role, as well as a loading for on costs. These costs will usually be adjusted on an annual basis to reflect levels of inflation, any changes in award rates, and to assess whether the on-cost loading percentage requires amending.
- **$0.08m p.a. ongoing rental costs.** This is based on 6% of infrastructure build costs and adjusted for inflation
- **$0.06m p.a. ongoing maintenance costs.** These are based on 4% of total infrastructure build costs and adjusted for inflation on annual basis. Maintenance costs would usually include service, repair and renovation of premises. When assets are owned by a third party, level of maintenance cost may be assumed by the owner. This position is usually negotiated between the landlord and tenant, and it is specified in the leasing agreement.
- **$0.1m p.a. other ECH operating cost.** Flexible cost allocation to address other cost requirements of the ECH. This is anticipated to include a range of non-staff operating costs

such as cleaning, gardening, IT related as well as glue related costs such as catering for events, local outreach travel, or design of promotional materials or publications.

This model assumes that the ECH can leverage existing community infrastructure of an ECEC space and play equipment and thus these are not incorporated in the costing of this model. **$1.39m once-off infrastructure build costs** have been included for glue and services space including consultation rooms, community rooms and informal space. Some hubs participating in the research noted the preferred delivery setting of primary schools, where existing funding entitlements and infrastructure provision reduce the costs of an ECH to the glue staffing costs ($560,000). This would be helpful to test with a larger sample in future research.

Hybrid model: This ECH model assumes that early learning, family support services and allied health & medicine are provided in-house. As detailed above, providers would usually choose inhouse delivery of services if these were insufficiently available or inaccessible to the community.

Total **operating cost per annum of $1.49m** incorporates:

- **$0.56m p.a. ongoing glue cost.** These are wages and superannuation paid to one ECH Coordinator, two Community Engagement Officers, and one administration role, as well as a loading for on costs. These costs will usually be adjusted on an annual basis to reflect levels of inflation, any changes in award rates, and to assess where the on-cost loading percentage requires amending.
- **$0.62m p.a. ongoing service staffing cost**. Representing salary and superannuation paid to a part time Educator, part time Social Worker to run playgroups and engage with families informally, four Social Workers providing family support services, and one Allied Health Professional as well as a loading for on costs. These costs will usually be adjusted on an annual basis to reflect levels of inflation and any changes in award rates, and to assess whether the on-cost loading percentage requires amending.
- **$0.13m p.a. ongoing rental costs.** This is based on 6% of infrastructure build costs and adjusted for inflation. The level of rent in this scenario is higher than rent in partnered delivery model, reflecting the need for more space.
- **$0.09m p.a. ongoing maintenance costs.** These are based on 4% of total infrastructure costs and adjusted for inflation on annual basis. Maintenance costs have increased in line with increase in infrastructure space.
- **$0.1m p.a. other ECH operating cost**. Flexible cost allocation to address other cost requirements of the ECH. This is anticipated to include a range of non-staff operating costs such as cleaning, gardening, IT related as well as glue related costs such as catering for events, local outreach travel or design of promotional materials or publications.

Similar to above, if co-location or usage of existing infrastructure were not available options, there would be a requirement of **$2.13m of initial, once-off infrastructure build cost** for glue and services space including a consultation room, community room, informal space, and play environment. This model assumes that the ECH is able to use existing community infrastructure of an ECEC space and this is not included in the total ECH model cost. The above model could be adjusted based on needs in different contexts.

In-house model: This represents an extreme scenario in which service access is highly constrained, and infrastructure is established through philanthropic or government grants. This illustrative scenario highlights the prohibitive infrastructure and service costs ECHs would face without government or philanthropic support, if required to provide all services in-house.

Total **operating cost per annum of $3.90m** incorporates:

- **$0.56m p.a. ongoing glue cost**. These are wages and superannuation paid to one ECH Coordinator, two Community Engagement Officers, and one administration role, as well as a loading for on costs. These costs will usually be adjusted on an annual basis to reflect levels of inflation, any changes in award rates, and to assess whether the on-cost loading percentage requires amending.
- **$2.31m p.a. ongoing service staffing cost**. This represents wages and superannuation paid to a part time Educator, part time Social Worker to help run playgroups, four Social Workers providing Family Support Services, one Allied Health Professional, 9.8 ECEC staff, three Maternal and Child Health professionals, one Allied Health Professional and two community designated activities workers as well as a loading for on costs and an allowance for resources. These costs will usually be adjusted on an annual basis to reflect levels of inflation, any changes in award rates, and to assess whether the on-cost loading percentage requires amending.
- **$0.56m p.a. ongoing rental costs.** This is based on 6% of infrastructure build costs and adjusted for inflation. These costs are materially higher than other models, representing the significant cost of the ECEC space.
- **$0.37m p.a. ongoing maintenance costs.** These are based on 4% of total infrastructure costs and adjusted for inflation on annual basis. Maintenance costs are applied when the infrastructure is owned by the ECH. If assets are owned by a third party, level of maintenance cost may be assumed by the owner or negotiated and specified in the leasing agreement.
- **$0.1m p.a. other ECH operating cost**. Flexible cost allocation to address other cost requirements of the ECH. This is anticipated to include a range of non-staff operating costs such as cleaning, gardening, IT related as well as glue related costs such as catering for morning tea events.

There is a $9.3m initial, once-off infrastructure build cost for glue and services space including consultation rooms, community rooms, informal space, play environment, as well as ECEC space. The most significant cost is the ECEC building, costing a total of $7.2m as it is assumed there is no existing community infrastructure that the ECH could leverage

Based on the above analysis, the most efficient and preferred ECH model for ECHs operating in geographies where core services are provided in the community and can be relocated and integrated within the ECH is the partnered delivery model. This approach to service delivery consolidates existing services into an integrated model within a trusted, welcoming environment. Additionally, it enhances efficiency and effectiveness of government (and non-government) service delivery, strengthens early intervention and avoids service duplication.

In areas where access to quality core services is challenged, viability of ECHs will depend on stable, long-term government funding and ability to co-locate within existing or planned government infrastructure i.e. government schools or ECEC.

7.3 ECH funding requirements

7.3.1 ECH glue

As noted above, integration must become normative. To embed integration or the glue into the system, governments and funders must both recognise and fund relational infrastructure as a core

requirement of ECHs and embed this in any ECH funding model. A central value proposition of the ECH model is its capacity to reach and deliver services to children and families who might not otherwise access these yet stand to benefit greatly. The community engagement function is essential for establishing the necessary relationships to facilitate this. Sustaining collaboration, supporting families holistically, building trusted relationships and improving child and family outcomes depends on providing sufficient long-term funding to the glue that holds integration together.

This recognition and funding of glue functionality should also extend to existing community embedded services that would benefit from undergoing conversion into an ECH based model due to the community demand. It should also recognise that glue funding needs will evolve, both over the lifecycle of an individual ECH, and the lifecycle of an ECH provider. Different ECH models must be feasible under any funding model, recognising different models are best placed to serve the needs of differing communities

In relation to ACCOs, in particular, the SNAICC funding model explored in the literature review costs up a base funding requirement for an ACCO integrated early years service within a small metropolitan community that has average or lower vulnerability. The proposed model aligns with the in-house service provision model articulated above; however, we note that the average cost of the 10 FTE glue and services staff required for this model is less than $67k per FTE (~$62k for glue, $70k for services). This estimate is notably lower than the costs observed and estimated within this research.

7.3.2 ECH services

Funding should reflect the true cost of service delivery within the ECH community, aligned to need, and must account for indirect costs of service delivery including operational expenses such as compliance, administration and overheads. While partnered delivery provision is the optimal model, it should be complemented by directly staffed services where this is required to meet community needs. The primary objective is that communities are consistently able to access necessary services irrespective of manner of provision. Although ECHs are not directly funded for these, partnered delivery services depend on third-party providers having adequate funding for service provision and ongoing viability, and funding arrangements that allow them to deliver these services at ECH locations and participate in integration activities.

To provide children and families experiencing a range of life challenges integrated service access and support them to navigate pathways, dedicated glue functionality is essential. Accessibility must also remain a cornerstone, with service delivery, models supporting free, low-barrier entry points important to maintain accessible and non-stigmatising environments.

Staffing models should account for the vulnerability of families accessing ECHs, particularly the higher staff ratios and more experienced staff that may be required, depending on the socioeconomic environment of the community in which the ECH operates. In addition to this, ECHs should have access to sufficient funding for experienced staff, which may require above-award wages to attract and retain skilled staff.

We note that a substantial range of services can be offered within ECHs, with varying staffing requirements and service intensity. These consequentially have significant variances in costs per service. As such the building blocks approach utilises a unit cost methodology which enables ECH

providers to conduct a bottom up build of service requirements that reflects their staffed service offering and community needs

Early learning

In the context of early learning, funding must recognise early learning including ECEC as a core component of the ECH model and especially critical given the location of ECHs in low socioeconomic communities, with developmental and learning benefits for children. It is critical that the ECEC funding system is viable for communities experiencing socioeconomic disadvantage. This includes ensuring that ECEC services are funded for the operational cost of ECEC service provision including above ratio and more experienced staff where required whether through fees, subsidies, block funding and/or equity loadings. The inadequacy of the current model means many children who stand to benefit most are missing out on critical learning opportunities. Service provision may be in-house or partnered delivery as required, which can be driven by community need, existing service provision and expertise of the ECH provider.

Health (Allied Health & Medicine)

ECHs consistently sought additional health service provision. While this could be provided by additional funding, an alternative solution may be provision of these staff via partnered delivery arrangements with the relevant local health district or State/Territory government, allowing services to be provided more efficiently and aligned to community requirements. The emerging Thriving Kids policy will also be relevant here, and if implemented effectively, it may reduce demand.

Providing services within an ECH may enhance efficiency, as the supportive, trusted and familiar environment can reach those not otherwise accessing services, reduce missed appointments and deliver avoided costs. Partnered delivery allied health and medicine provision also removes ECH responsibility to recruit, manage and provide the necessary professional supervision and regulatory oversight for these staff. In these instances, the service provider should allow flexibility within the service provision for these staff to undertake integration activities and provide services flexibly to meet community needs.

7.3.3 ECH infrastructure

Overview

The ECH funding model generally assumes no infrastructure costs such as rent, repairs or maintenance, given the breakeven nature of many ECH budgets, and noting that program funding may only cover costs associated with direct delivery. For ECHs to remain financially viable, it is currently a requirement for infrastructure to be provided at no or minimal cost (i.e. peppercorn rent) to the ECH. The size of these costs, including rent, maintenance and capital expenditure, would otherwise undermine the ongoing sustainability of ECHs who often operate on tight budgets. To support the ongoing continuity and stability of the ECH, it is essential for infrastructure to be provided at no cost and under a long-term arrangement.

In terms of the facilities themselves, ECH providers consistently highlighted the integral role purpose-built facilities play in ECHs integrated service delivery and limitations on repurposing existing buildings. These ECHs incorporate key spaces across indoor and outdoor locations including an informal community space, multipurpose rooms, shared staff rooms, consulting rooms and an early learning space. Single front-door entry points also destigmatise access and promote engagement with different service offerings.

> *"We're lucky our hubs are purpose built and designed for kids. This has been key to their success."* - ECH provider

We need to recognise however, that it can be very difficult to find appropriate land in optimal locations for ECHs and this may not always be possible. In considering new infrastructure builds, there may be scope to leverage existing community facilities or add onto new builds of schools or ECECs to reduce costs and leverage shared facilities.

Ongoing maintenance of these facilities as well as cleaning and gardening expenses must also be incorporated into programmatic funding or covered in-kind by the facility owner, as requiring ECHs to fund these directly places considerable strain on already tight budgets. Where providers own their buildings, dedicated access to grants or program funding should be available to cover true lifecycle costs, including renovations and major repairs. Without this, service delivery can be compromised, or staff are burdened by sub-optimal facilities.

7.4 Recommendations

For all recommendations, deep engagement with communities on their specific needs, priorities and gaps in early years supports is a critical first step to better understand and meet the needs of children and their families. This should include strong commitment to shared decision-making, self-determination and cultural governance, in alignment with Closing the Gap Priority Reform One[19].

1. **Integration:** Federal, state/territory and local governments prioritise integration in all reform opportunities to work towards a joined-up child and family system that enables seamless provision of child and family centred services and supports to communities experiencing significant socioeconomic disadvantage.
2. **Long term funding mechanism:** Federal, state and territory governments agree on and implement a long-term, adequate funding model to support establishment and ongoing operation of ECHs in areas with significant socioeconomic disadvantage, including adequate glue funding, flexible funding to support priority family needs, adequate rent, ongoing maintenance and building management costs (as relevant respectively). Prioritisation on primary school sites is recommended (where appropriate), with existing funding entitlements and infrastructure provision often providing optimal environment.
3. **ACCO growth and funding:** Federal and state/territory governments establish a specific funding mechanism for integrated Aboriginal and Torres Strait Islander ACCO early years services in accordance with the SNAICC ACCO Funding Model report[20], ensuring proportionate investment based on child need, and support mechanisms to grow and sustain the ACCO early years sector.
4. **Infrastructure:** Federal, state and territory government infrastructure grants, including the Building Early Education Fund (BEEF), reflect actual ECH property development costs, and are accompanied by funding for ongoing maintenance and building management costs where ECHs own buildings, or property rental and related costs where they do not.

[19] Parliament of Australia (2020). Priority Reforms. Closing the Gap. Retrieved from https://www.closingthegap.gov. au/national-agreement/priority-reforms

[20] SNAICC (2024). *Funding Model Options for ACCO Integrated Early Years Services: Final repor*t. https://www.snaicc.org.au/wp-content/uploads/2024/05/240507-ACCO-Funding-Report.pdf

5. **Building Early Education Fund:** BEEF investments include at least $1.39 million, with additional loadings for geographical complexity, for set up of an ECH around every long day care service established through the fund, to unlock service access, intervene early and improve child and family outcomes.
6. **ECEC funding reform:** The Australian Government reform the ECEC funding model to ensure services are funded for the full operational cost of ECEC service provision (through fees, subsidy and equity loadings) including more experienced and above ratio staffing where required.
7. **Interim expansion of Community Child Care Fund (CCCF):** While the ECEC funding model is under review, the Australian Government expand the CCCF to fund the ECEC operational gap and integration glue for ECHs. Funding for ongoing maintenance and building management costs where ECHs own the building or property rental and related costs where they do not, is also a critical component. SVA recommends prioritisation of existing ECHs with no glue, or those facing sustainability risks, to unlock significant impact quickly.
8. **Thriving Kids:** The Australian Government embed ECHs within the Thriving Kids Program as one key pathway for implementation to support integrated provision of supports for children with developmental needs.
9. **Further costings research:** Federal, state and territory governments, philanthropy and the sector collaborate on a next phase of larger scale research on the cost of provision of high quality ECHs, to complement and accompany the Australian Government Early Education Service Delivery Prices Project.
10. **SROI investment:** Sources of non-government funding such as philanthropic funding invests in Cost Benefit and Social Return on Investment research to build an understanding not only of the costs of ECH provision, but the social and economic benefits.
11. **Strengthen articulation of the glue:** ECH leaders continue to strengthen the articulation and measurement of the glue, supporting it to become a more visible and explicit deliverable.
12. **Test Building Blocks model:** Organisations interested in establishing or transitioning into an ECH work with SVA to test the Building Blocks model articulated in the report.

8. Conclusion

This report aims to contribute to the existing literature, noting limited available research on ECH costings. This is a fundamental aspect to understand in order to support the provision of ECHs at any substantial scale and improve support and outcomes for children and families experiencing significant socioeconomic disadvantage across Australia.

Strikingly, the research did not support the hypothesis that ECEC would enhance ECH service viability through cross-subsidising the glue. In contrast, most ECH providers operating ECECs were required to draw on other funding or staffing to support ECEC service provision, posing a potential financial viability risk. Despite this, ECH providers continued to offer these ECEC services due to various benefits they identified including supporting children's learning, development and wellbeing, early intervention, offering a safe and supportive environment for children and respite for carers. This highlights a broader systemic ECEC funding issue in areas of high socioeconomic disadvantage and the urgent need for reform of the ECEC funding model. Future research could explore solutions for profitable integrated ECEC services and ECHs, potentially drawing support from public and private sectors.

Given the significant variability between ECHs, including the needs of the communities they service, and existing service provision within these communities, costs and service provision requirements varied significantly between ECHs. The costing model incorporates key costing components to allow ECH providers to consider these, when they indicatively cost their ECH. It also identified three indicative models based on community needs and service availability within the community; partnered delivery; hybrid and in-house. This research suggests that partnered delivery is ultimately the preferred model, however requires a series of conditions to be in place: 1) Quality services are available in the community, and they have the flexibility to be able to offer services within the ECH for an integrated service offering, and 2) the services are values aligned and support the integrated ECH culture.

In-house provision may be preferred when services are unavailable in the community or unable to be provided in a way that meets the needs of family participants, and the ECH provider has the relevant expertise or is able to source this to provide in house.

The research developed a costing model that ECH providers can utilise to calculate establishment and ongoing costs for their proposed ECH, taking into account community needs and existing service provision. Our findings demonstrate four key cost components for ECHs:

- Glue (staffing)
- Services (staffing)
- Purpose built infrastructure, and
- Other expenses.

The building blocks model has been designed to reflect that cost components will vary between ECHs and communities. This will be driven by the model that the ECH provider adopts in response to community requirements, availability of services within the community and community infrastructure. Costs will further differ driven by features such as differing costs for various components across rural/regional/remote/states/territories. We do note that in the three indicative models proposed in this report will have a core glue component, recognising the fundamental need for integration work in all ECHs.

To ensure the sustainability and effectiveness of ECHs, it is critical to have a viable funding model that addresses the costs of service delivery, including indirect costs such as compliance, administration, and infrastructure maintenance. The funding model should be flexible to adapt to community needs and support both newly established ECHs, existing ECHs and existing community-embedded organisations transitioning to an ECH structure. Key funding requirements include:

- **Secure, long-term funding**: Funding that covers all ECH delivery costs reduces reliance on short-term grants and fragmented income sources and allows sufficient flexibility to meet community needs.
- **Integration glue funding**: Recognising and funding the glue that holds integration together as core and non-negotiable, including relational infrastructure and indirect head office costs.
- **Service delivery funding**: Funding needs to reflect the actual cost of service delivery, including higher staff ratios and more experienced staff for communities with higher needs. Policy settings and funding flexibility that supports use of partnered delivery service provision with the necessary conditions for success to meet community needs.
- **Infrastructure Funding**: This provides purpose-built infrastructure and related requirements at no or minimal cost to the ECH. This utilises an ECH funding model that ensures the provision of infrastructure and associated requirements through partnered delivery to the ECH, allocates adequate funding for the ECH to cover these expenses, or employs a combination of both approaches. This must include long-term arrangements to ensure stability and continuity.

A fit for purpose funding model will ensure that ECHs can continue and expand to meet community needs in a sustainable and viable way, improving outcomes for children and families across Australia.

Appendix A - Reference list for literature review

- Confidential Report 1.
- Confidential Report 2.
- Confidential Report 3.
- Deloitte Access Economics. (2023). Exploring need and funding models for a national approach to integrated child and family centres. https://www.deloitte.com/au/en/services/economics/perspectives/exploring-need-funding-models-national-approach-integrated-child-family-centres.html
- SNAICC. (2024). Funding model options for ACCO integrated early years services Final report. https://www.snaicc.org.au/resources/funding-model-options-for-acco-integrated-early-years-services-final-report/
- Social Ventures Australia. (2023). Happy, healthy and thriving: enhancing the impact of our Integrated Child and Family Centres in Australia, https://www.socialventures.org.au/our-impact/enhancing-the-impact-of-integrated-early-years-supports-in-australia/
- Social Ventures Australia. (2024). Maximising impact through integrated early childhood hubs: What good looks like. https://www.socialventures.org.au/wp-content/uploads/2024/10/What-good-looks-like-brief-Victoria.pdf
- Social Ventures Australia & Murdoch Children's Research Institute (2023). Exploring Need and Funding Models for a National Approach to Integrated Child and Family Centres: Summary Brief. August. https://www.socialventures.org.au/wp-content/uploads/2024/07/Final-Deloitte-brief-Aug-2023.pdf

Appendix B – Assumptions list

Overarching assumption		Numbers by necessity have relied on multiple assumptions. A number of assumptions were made to derive data, with publicly available data, interview feedback and RFI responses used to derive quantitative inputs to the model approach.
Revenue	**Quantum**	Based on verbal feedback from ECH providers, it is assumed that revenue is equal to costs.
	Funding model	Types of funding and length of funding have been sourced from available data. Where financial data or specific information was unavailable, various assumptions were used leveraging other information provided.
Staffing costs	**Salary**	Based on information from ECHs where provided. Where unavailable, based on publicly available job advertisements and/or the midpoint of the relevant award rate (except where role complexity indicates greater seniority is required) Where ECH providers indicated higher than award rates are required, an estimated loading was added based on feedback and publicly available information. Costs include salary, super and 25% on cost loading and have been calculated in FY26 numbers. Where financial information has been provided, award data has been used to disaggregate.
	Glue	Where glue FTE isn't explicitly indicated, we quantified insights from ECH provider as to proportion of staffing engaged in glue role/s.
	Staffing assumptions	Where FTE staffing levels were not provided, various assumptions including based on service size are used to derive these.
	Other salary assumptions	Staff costs include salary, 12% superannuation and 25% loading. It is assumed that the FTE of most roles are 38 hours per week, 52 hours per year, except for limited school-based roles.
Services	**Partnered delivery providers**	Calculation of staffing and frequency for partnered delivery service providers is derived from various feedback provided. We have assumed external service provision is partnered delivery, except where this has been otherwise noted.
	Partnered delivery provider loading	We calculated the cost of partnered delivery service provision by considering the staff required to supply the service (based on ECH provider feedback), and the amount of time service provision would take. This was multiplied by a loading to incorporate additional costs attributable to the organisation delivering the service offsite. The loading varied dependant on whether the partnered delivery provision was a staff member (i.e. an allied health professional working from the ECH for a day a week), or a specific service (i.e. a playgroup).

	No. services provided	Based on information provided by ECH and publicly available information. Service counts do not incorporate service delivery intensity.
Infrastructure	**ECH set up**	Information on number of rooms drawn from interview notes and feedback. Assumptions were made to categorise room size and quantum where this information was not available.
	ECH room size	Room size for building blocks model was determined using publicly available data. A loading was applied to account for categories such as corridors and bathrooms.
	Rent	Assumed to be 6% of build costs
	Maintenance	Assumed to be 4% of build costs
	Build costs	Assumed to be $8,000 per m^2. Land cost has not been included.
Other	**ECH Aggregation**	In some cases, a single ECH may represent multiple sites or ECHs. We have aligned with ECH provider guidance on this.
	Aggregation	Assumptions have been made to aggregate data from multiple ECH providers into broad financial categories. We have also aggregated service provision into broad categories.
	Indexation	Data has been indexed to FY26, using award indexation or inflation as appropriate.

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