Name: Anonymous

Submission date: 6/06/2025

Participant background

1. For the purposes of this consultation, which of the following best describes you:

   I am an industry or advocacy organisation, professional association or peak body

2. Which of the following care sectors will your feedback relate to? Please select all that apply.

   Health

3. What kind of care supports, services and programs do you have experience with, and in what jurisdictions?

   The participant did not respond to this question.

1. Reform of quality and safety regulation to support a more cohesive care economy

1. To what extent do differences in quality and safety regulation make it costly or complex to provide or access care services?

   The participant did not respond to this question.

2. What are the reasons for your answer?

   The participant did not respond to this question.

3. To what extent should quality and safety regulations be more aligned across the different care service sectors and jurisdictions?

   The participant did not respond to this question.

4. What are the reasons for your answer?

   The participant did not respond to this question.

2. Embed collaborative commissioning to increase the integration of care services

1. What is your experience with collaborative commissioning

   We worked with a Local Health Network (LHN) to implement a highly innovative program to reduce rehospitalisations from heart failure in their network given the significant burden of the condition in their community. Nationally, heart failure costs the healthcare budget around $1 billion per year – with around two thirds of this incurred from hospital services. Around 25% of patients with heart failure are readmitted to hospital within 30 days.
   We collaborated with the LHN and a digital health provider to design a trial to provide of an end-to-end service to reduce rehospitalisation rates, particularly given access to GPs is a problem in the area. The LHN also collaborated with their PHN.
   The proposed trial included the identification of biomarkers to optimise and guide up-

titration of heart failure medicines and the use of a digital health tool enabling patients to self-manage their condition and enabling continuous remote monitoring. The trial also involved a value-based payment model (paying for outcomes), not a fee for service.
The LHN was keen to deliver this project but obtaining funding from the State Government ($200,000) to run the project was difficult. As a last resort, the LHN considered seeking State Government approval to repurpose grant funding provided for another project related to improving heart health. However, the LHN considered the risks in this approach too great.
Consequently, after 2 years of effort, the difficulty in obtaining funding resulted in the LHN deciding not to pursue the project. This resulted in a missed opportunity to provide an innovative model of patient-centred care that would have resulted in better health outcomes at lower overall healthcare costs and trialled a value-based payment model (rather than a fee for service).

2. What are the benefits of pursuing greater collaborative commissioning?

   Delivering quality care more efficiently and providing better outcomes for patients.

3. What are the barriers to collaborative commissioning, and do you have any suggestions for solutions that would lead to better collaboration in the commissioning of care services?

   See response to questions above.

3. A national framework to support government investment in prevention

1. What are the main barriers to governments investing in evidence-based prevention programs across the care economy?

   Implementation of prevention programs may have a significant immediate budgetary impact with delayed returns on investment and / or lack of cost-effectiveness. Given competing demands for healthcare funding, payers tend to favour health interventions where the health outcomes are realised over short time frames (such a few weeks rather than years) and where cost-effectiveness is easier to demonstrate.
   There are numerous technicalities which contribute to the challenges in demonstrating cost-effectiveness using traditional health technology assessment (HTA) and the lack of appetite by HTA committees to consider other types of economic analyses such as a social return on investment analysis which measure the economic return per dollar spent.
   It is also because healthcare spending is viewed as a cost, rather than as an investment by central agencies in the Government.

2. What are some examples of successful prevention programs (this could include discontinued programs)?

   The National Cervical Screening Program (NSCP) is an incredibly successful public health initiative which was implemented by the Australian Government in 1991, prior to the introduction of HTA for all funding decisions involving health technologies and screening programs.
   Investing in the NSCP has placed Australia on track to be the first country in the world to eradicate cervical cancer by testing women for Human Papilloma Virus and providing vaccination.
   It is unlikely that implementation of the NSCP would have been found to be cost-effective (and therefore implemented) if an HTA had been conducted. This is because it

is always challenging to demonstrate cost-effectiveness when the costs of delivering a new intervention (a national screening program) are significantly higher than the cost of providing standard of care (and when the benefits are realised many years later and where the prevalence of the condition / biomarker being tested for is low).
It should be noted that once a screening program is implemented and it therefore becomes standard of care, the cost-effectiveness of any changes to the program are easier to demonstrate. This is because the 'gap' between the cost of the program, which is now standard of care and the proposed change to the program is much smaller that the gap that existed between the standard of care in place before the program was established (i.e. the previous standard of care). For example, an HTA for changes to the NSCP in 2014 (a broader patient population and longer intervals between testing using new technologies) found the changes to be cost effective.

3. How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?

The Australian and State Governments should provide national leadership in identifying and agreeing priority areas for prevention and provide funding through the National Health Reform Agreement for activities to support prevention in these priority areas.
Rather than using Australian-preferred HTA methods and their focus on the narrow definition of value (Quality Adjusted Life Year (QALY)) to inform Government funding decisions for preventive health programs, the following types of analyses may be more informative:

- Conducting a social return on investment analyses to consider the economic and social benefits of investing in preventive health interventions (and considering health expenditure an investment, not a spend).
- Multi-Criteria Decision Analyses – an economic tool used to inform complex and multi-factorial choices that help to capture different dimensions of value from different perspectives.