Delivering quality care more efficiently inquiry

Questionnaire response 63

Name: Medical Technology Associaton of Australia

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

   Question 1: What is your experience with collaborative commissioning?

   1.1 THE RELATIONSHIP BETWEEN COLLABORATIVE COMMISSIONING AND VALUE BASED PROCUREMENT

   Collaborative commissioning is a model of care planning and delivery where multiple organisations—such as Primary Health Networks (PHNs), Local Hospital Networks (LHNs), and Aboriginal Community Controlled Health Organisations (ACCHOs). These entities can work together to identify population needs, co-design services, procure care, and evaluate outcomes. This procurement models intends to reduce fragmentation,

close service gaps, and improve outcomes by aligning efforts across sectors and levels of government.

Similar to the concept of Collaborative Commissioning is the concept of Value-Based Procurement (VBP), which can be considered a form of collaborative commissioning. VBP is based on the principles of Value Based Healthcare which focuses on achieving the best possible health outcomes for patients relative to the total cost of care, considering the entire care pathway. VBP applies this by shifting procurement decisions away from lowest-cost purchasing toward those that deliver the greatest value—measured through improved patient outcomes and system efficiencies.

What distinguishes VBP from traditional collaborative commissioning is its broader stakeholder engagement to determine value for a range of key health stakeholders. While collaborative commissioning often involves coordination between government health entities, VBP brings together generally a wider group of actors—clinicians, patients, suppliers, policy makers, and procurement leaders. This inclusive approach ensures that procurement decisions are informed by clinical insight, patient needs, and innovation, not just administrative or budgetary considerations.

1.2 Examples of how VBP in practice

MTAA has identified examples of VBP initiatives in Australia that are done at a local level involving multiple stakeholders involved in delivering care along a patient's journey, demonstrating how it could be embedded as part of a scale up collaborative commissioning approach across both the public and private health systems.

EXAMPLE 1: Care4today Program

In the Care4today program, Johnson & Johnson MedTech partnered with St Vincent's Hospital to reduce hospital length of stay (LOS) for joint replacement surgeries. The initiative involved clinicians, hospital administrators, and the supplier working together to redesign care pathways.

1. Problem Identification

The program was initiated to address the backlog of elective surgeries and reduce hospital length of stay (LOS) for joint replacement procedures, while maintaining or improving patient outcomes.

2. Stakeholder Collaboration

A partnership was formed between Johnson & Johnson MedTech and St Vincent's Hospital. This was a long-term collaboration focused on shared goals.

3. Program Co-Design of Care Pathway

- Pre-operative and post-operative patient education
- Streamlining at-home care
- Standardising wound closure products to reduce infection risk
- Identifying inefficiencies in surgical management with clinical teams

4. Implementation and Support

The supplier worked closely with clinicians to implement the redesigned care pathway, providing tools, training, and support throughout the process.

5. Outcome Measurement

- LOS for total knee replacement reduced from 3.95 to 2.75 days
- LOS for total hip replacement reduced from 5.41 to 3.44 days
- Additional benefits included reduced complications and faster recovery

6. Value Delivered

The program generated financial savings through shorter hospital stays and improved

patient throughput, demonstrating value beyond the product itself.

EXAMPLE 2: Case Study 2: Preventing Surgical Site Infections (SSIs)
1. Problem Identification
Surgical Site Infections (SSIs) account for approximately 15% of all healthcare-associated infections in Australia. In NSW alone, 12% of 10,700 healthcare-associated infections in 2020–21 were SSIs. These infections lead to longer hospital stays, increased patient discomfort, and significant additional healthcare costs—up to $42,102 per case.
2. Stakeholder Collaboration
The initiative involves collaboration between healthcare providers (e.g. hospitals and surgical teams), procurement teams, and medical technology suppliers. This approach also aligns with clinical guidelines from the National Health & Medical Research Council and the World Health Organization, which recommend the use of antimicrobial sutures to reduce SSIs.
3. Program Co-Design of Care Pathway
• Identifying high-risk surgical procedures prone to SSIs.
• Selecting wound closure products (e.g. antimicrobial sutures) with proven efficacy in reducing infection rates.
• Incorporating supplier-led training and support to ensure correct product usage.
• Designing procurement contracts that link product use to measurable clinical outcomes.

4. Implementation and Support
Suppliers would not only provide the products but also support implementation through education, training, and outcome monitoring. Hospitals would be equipped to track infection rates and assess the impact of the intervention.
5. Outcome Measurement
Hospitals would monitor SSI rates before and after implementation. Suppliers would be held accountable for demonstrating reductions in infection rates, with performance benchmarks potentially tied to contract terms.
6. Value Delivered
This VBP model shifts procurement from a cost-based to an outcome-based approach. It delivers value by:
• Improving patient safety and recovery
• Reducing avoidable hospital stays and associated costs
• Enhancing system efficiency
• Potentially saving the health system up to $1.5 billion annually if all hospitals achieved the safety levels of the top 10%

What these examples mean:
Both examples demonstrate how VBP extends collaborative commissioning by engaging a broader group of stakeholders—including industry, clinicians, and patients—in the design, delivery, and evaluation of care. Rather than focusing solely on cost or administrative coordination, VBP fosters partnerships that are outcome-driven, evidence-based, and centred on delivering value across the care continuum.

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

Question 2: What are the benefits of pursuing greater collaborative commissioning?

2.1 BENEFITS PURSUING COLLABORATIVE COMMISIONING AT SCALE

Pursuing greater collaborative commissioning—particularly through value-based procurement (VBP)—offers significant benefits across the healthcare system by aligning stakeholders around shared goals of improving outcomes and efficiency.

For the Health System

Collaborative commissioning enables smarter resource allocation by focusing on interventions that deliver measurable improvements in patient outcomes. VBP, as a form of collaborative commissioning, shifts procurement from cost-based decisions to those based on long-term value. This reduces waste, avoids duplication, and supports sustainability. For example, programs like Care4today reduced hospital length of stay for joint replacements, freeing up capacity and reducing costs without compromising care quality.

For Patients

Patients benefit directly from services designed around their needs and outcomes. VBP initiatives incentivise suppliers and providers to deliver holistic, outcome-focused care. In the Care4today example, patients experienced shorter hospital stays and improved recovery pathways. Similarly, procurement strategies targeting reduced surgical site infections improve safety and reduce complications, enhancing patient experience and health outcomes.

For Clinicians

Clinicians are empowered through collaborative commissioning models that value their input in designing and evaluating care solutions. VBP encourages partnerships between clinicians and suppliers to co-develop care pathways, as seen in the orthopaedic procurement initiative. This fosters clinical ownership, supports evidence-based practice, and reduces administrative burden by aligning procurement with clinical goals.

For Procurement Teams

Procurement professionals' benefit from clearer, outcome-driven frameworks that support strategic purchasing. VBP provides a structured approach to assess value beyond price, incorporating real-world evidence and long-term impact. This enables procurement teams to make informed decisions that align with broader health system objectives, while also fostering innovation and supplier accountability.

What this means:

In summary, collaborative commissioning through VBP creates a more integrated, efficient, and patient-centred care system. It enhances outcomes, reduces inefficiencies, and builds stronger partnerships across the care economy—delivering benefits that extend well beyond traditional procurement models.

2.2 ROLE OF DIGITAL HEALTH IN IMPLEMENTING COLLABORATIVE COMMISSIONING

Building on the benefits of Value-Based Procurement (VBP) as a form of collaborative commissioning, digital health technologies offer a critical enabler for scaling and sustaining these models across the care economy.

Digital health, as it relates to medical technologies, refers to the integration of digital tools and systems into healthcare delivery to enhance clinical decision-making, improve patient outcomes, and increase system efficiency. In the MedTech context, digital health encompasses a wide range of technologies that go beyond traditional medical devices by incorporating data, connectivity, and intelligence into care pathways.

Examples of digital health product categories in the MedTech space include:

- Remote monitoring devices (e.g. wearable sensors for cardiac or glucose monitoring)

• AI-enabled diagnostic tools (e.g. imaging software that detects abnormalities)
• Surgical robotics and navigation systems (e.g. systems that assist in precision surgery)
• Digital therapeutics (e.g. software-based interventions for chronic disease management)
• Connected care platforms (e.g. telehealth systems and virtual care coordination tools)
These technologies not only support clinical care but also generate valuable data that can inform population health strategies and procurement decisions.

How Digital Health Supports Collaborative Commissioning
Digital health supports collaborative commissioning by providing the infrastructure and intelligence needed to design, implement, and evaluate Value Based Procurement models. Digital tools such as advanced analytics, artificial intelligence (AI), and real-time data platforms can help governments and health services better understand population needs, identify service gaps, and monitor the impact of interventions.
For example, AI and predictive analytics can be used to forecast patient demand, stratify risk, and identify cohorts that would benefit most from targeted, collaborative interventions. This enables commissioning bodies (eg LHDs, (PHNs), and ACCHOs) to co-design services that are proactive rather than reactive. These insights also support procurement teams in selecting technologies and services that are most likely to deliver measurable improvements in outcomes and efficiency.
Moreover, digital health platforms such as the Single Digital Patient Record (SDPR) and integrated staff tools (e.g. the Digital Front Door app) enhance coordination across providers and streamline workflows. This reduces duplication, improves continuity of care, and ensures that data is available to inform procurement and commissioning decisions.
By embedding digital health into collaborative commissioning, governments can strengthen their capability to deliver value-based health care. This includes using real-world evidence to evaluate supplier performance, adjusting care pathways based on outcomes, and ensuring that procurement decisions are aligned with long-term system goals.
In summary, digital health is not just a support tool—it is a foundational enabler of collaborative commissioning through Value Based Procurement. It empowers stakeholders with the data and systems needed to deliver integrated, efficient, and patient-centred care.

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?

Question 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?

In your response to this question, you might want to provide specific suggestions about changes to governance or funding that could lead to greater collaboration between PHNs, LHNs and ACCHOs, or feedback on any additional considerations for ACCHOs collaborating with LHNs and PHNs.
3.1 BARRIERS TO COLLABORATIVE COMMISSIONING
Collaborative commissioning faces several barriers that limit its uptake and effectiveness across the care economy. From MTAA's perspective, key challenges include:

Fragmented Governance and Procurement Silos
One of the primary barriers is the lack of coordination between different levels of government and across departments. Procurement processes are often siloed, with limited mechanisms for joint planning or shared accountability. This fragmentation makes it difficult to align funding, service design, and outcome measurement across sectors such as health, disability, and aged care.

Limited Stakeholder Engagement
Collaborative commissioning is often confined to government entities, excluding key stakeholders such as industry partners. This narrow approach limits innovation and fails to leverage the expertise of those directly involved in care delivery and technology development.

Lack of Awareness and Uptake at the Local Level
Even where value-based procurement initiatives exist, such as the NSW statewide orthopaedic contract, there is limited awareness and adoption among Local Health Districts (LHDs). This reflects a broader challenge in translating central policy into local practice.

Inadequate Use of Data and Outcomes Measurement
Effective collaborative commissioning requires robust data to identify needs, track outcomes, and evaluate impact. However, many systems lack the digital infrastructure and analytical capability to support this. Without clear metrics, it is difficult to hold partners accountable or demonstrate value

3.2. SOLUTIONS TO STRENGTHEN COLLABORATIVE COMMISSIONING
• Encourage the Commission to adopt MTAA Procurement Principles, which provide a practical framework to enhance collaborative commissioning models. These principles include
• Professionalise procurement to ensure high standards and consistency across jurisdictions .
• Focus on value and outcomes for patients, clinicians, and the health system, rather than lowest-cost purchasing.
• Foster genuine partnerships between government and industry, enabling co-designed solutions.
• Support innovation, ensuring that procurement processes do not act as a barrier to the adoption of new technologies.
• Embed Value-Based Healthcare into Procurement activity: Integrating VBHC into broader procurement strategies ensures that purchasing decisions support long-term health outcomes, not just short-term cost savings.
• Invest in Digital Health Infrastructure: Enhancing AI and data analytics capabilities enables predictive modelling, risk stratification, and real-time outcome tracking—critical tools for planning and evaluating collaborative initiatives.
• Promote Local Engagement and Capacity Building: Targeted support for LHDs and PHNs to adopt collaborative models, including training and incentives, can bridge the gap between policy and practice.

By addressing these barriers, collaborative commissioning can become a more effective, inclusive, and outcomes-driven approach to delivering quality care.

NSW Special Commission of Inquiry into HealthCare Funding - Recommendations on Procurement

The NSW Special Commission of Inquiry into Healthcare Funding (2025) made key recommendations to embed value-based healthcare principles into procurement processes across NSW Health. These recommendations were informed by stakeholder submissions, including the Medical Technology Association of Australia (MTAA), and supported by evidence from the MTAA commissioned Alira Health report on Value-Based Procurement in Australia. The Inquiry recognised the need for systematic approaches to defining, evaluating, and embedding “value” in procurement—beyond cost—to include patient outcomes, clinical input, and broader system benefits. It also called for formalised roles for agencies such as the ACI and CEC in procurement processes. These findings underscore the importance of aligning procurement frameworks with value-based healthcare objectives to drive better health outcomes and system efficiency. MTAA encourages the Productivity Commission to examine these in parallel to MTAA’s submission.

Conclusion

MTAA recognises the growing pressures on the health system, including rising demand, workforce constraints, and fiscal sustainability challenges. Collaborative commissioning, through leveraging value-based procurement, offers a practical pathway to address these challenges. It enables health organisations to work together across sectors and jurisdictions, aligning services with population needs and ensuring that investments deliver measurable improvements in outcomes.

MTAA strongly supports the Commission’s focus on embedding collaborative commissioning across the care economy. We believe this approach must be underpinned by:

• Inclusive, multi-stakeholder engagement—including clinicians, patients, suppliers, and policymakers
• A shift from volume-based to value-based funding and procurement models
• Investment in digital health and data analytics to support planning, monitoring, and evaluation
• Streamlined regulatory and procurement processes that enable innovation and responsiveness

MTAA urges the Commission to recommend the development of a national framework that supports collaborative commissioning and incentivises Value Based Procurement models. This should include mechanisms to scale successful initiatives, share best practice, and ensure that procurement and commissioning decisions are informed by real-world evidence and long-term value.

MTAA welcomes the opportunity to continue working with government and sector partners to advance these reforms. By embracing collaborative commissioning through Value Based Procurement, Australia can build a more sustainable, equitable, and high-performing care economy that delivers better outcomes for all.

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?

The participant did not respond to this question.

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

The participant did not respond to this question.

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

The participant did not respond to this question.

Cover sheet: Supporting document #1

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Lidia Szabo joined Alira Health as a consultant in MedTech market access for Europe and Asia Pacific in December 2022. Lidia has over ten years of experience in consulting roles in telecommunications and healthcare. Lidia has worked for both IQVIA and KPMG where she gained experience in management consulting from assistant to senior consultant roles. Major projects focused on pricing and regulatory strategy, business planning, and business process improvement. Lidia joined Alira Health through the partnership with Centivis AG, a market access consulting firm specialising on Diagnostics, where she was an Associate Consultant. Her expertise includes business development and market access for MedTech companies. Lidia holds two Master's Degrees, one in Economics from the Budapest University of Economics and the other in International Relations and European Studies from the Central European University. She is also an alumna of the Rajk László College for Advanced Studies.

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Simon focusses on health economics, market access, and pricing of medical devices, including diagnostics and digital health. He contributes to Alira Health's Value-Based market access solutions for MedTech enabling cross-functional, evidence-based teams within MedTech organizations to engage in external collaborative dialogue.Simon holds a master's degree in Biomedical Engineering (Ghent University & Politecnico di Milano), a master's degree in Management and Policy of the Belgian Healthcare System (KULeuven) and a master's degree in Healthcare management, Economics and Policy (SDA Bocconi). He has completed a 1-year program on Clinical, Regulatory and Quality affairs for medical devices (HEIG-VD) and completed the Harvard Business School Intensive Course on Value Based Healthcare.

Executive Summary

Healthcare systems globally are facing critical financial and operational challenges. Australia is no exception. If left untreated, these challenges will significantly impact delivery, access, and quality of Australian healthcare. Globally, and within Australia, the funding and financing of healthcare systems has emerged as one of the greatest public health risks.

With a relatively strong healthcare system, Australia has the opportunity of addressing these challenges. Australia's healthcare system is ranked high globally. The average life expectancy is 83.2 years and health spending is approximately 10.2% of gross domestic product (GDP). This places Australia 11 out of 38 of the Organisation for Economic Co-operation and Development (OECD) countries and above the median healthcare spend of 8.05% GDP. [2,3,4,5,6] However, despite ranking near the top of global comparisons, Australian healthcare is at risk of sleepwalking into a major funding, access, and healthcare delivery challenge.[17]

Australia had an estimated gross debit of AUD 885.5 billion in April 2022 and nearly 60% of GDP.[4] Debt levels will be compounded by worsening economic conditions including rising interest rates, and the highest level of inflation in generations.[4] At the state level, this dynamic is arguably most acute in Victoria, with a larger debt level in June 2022 than the combined total of NSW, Queensland and Tasmania in both nominal terms and as a share of gross state product. However, the gap is larger now than it is projected to be in June 2026.[7]

The immense financial pressures are further compounded by alarming demographic factors, including an aging population, an increased prevalence of chronic disease, both leading to significant increases in healthcare consumption. Inefficiencies in Australian healthcare are also an area for concern. [8] There is also the fragmented funding between hospital and general practice restricting the integration of care. Healthcare spending accounts for approximately 10.2% of overall GDP. With a strong demographic case for increasing healthcare spending, and with major inefficiencies within the existing spend, healthcare can be both a potential source of positive change if managed well, but also exacerbate the problem if left unaddressed.

Value-based healthcare presents a viable solution to this dynamic. Value-based healthcare is a care-delivery model that measures health outcomes versus the total costs of delivering healthcare: it aims to improve both patient outcomes and healthcare efficiency. Value-based healthcare ensures the entire patient pathway is considered, with the patient at the centre of the equation.[1]

More specifically, across the patient pathway, procurement and purchasing decisions are made for services and medical technologies. Value-based procurement ensures health outcomes are the primary determinants for these purchasing and procurement decisions. If this happens, VBP can be a significant enabler to VBHC.[9,10] However, VBP is not holistically happening across Australia. This needs to change, and Australia needs to follow the lead of other countries/regions that are already experiencing success in VBHC and VBP. Examples include Canada, the European Union (EU), England and Wales. In these countries, and others, there are examples of how health outcomes have been improved, and total costs reduced.[9,10,11,12,13,14,15]

This White Paper brings all of these themes together and makes 5 clear recommendations on VBP and VBHC implementation. This White Paper is substantiated by extensive desk research, and expert interviews with multiple stakeholder groups and Australian healthcare leaders. Both the research and expert opinions clearly see VBHC and VBP as an essential solution to rectify the Australian healthcare.

The 5 recommendations are:

Recommendation 1: Build a supportive ecosystem and form a VBP Community of Practice.

Recommendation 2: Build clinical engagement and leadership.

Recommendation 3: RWE to support procurement decisions.

Recommendation 4: Innovative Funding Models and Risk Sharing.

Recommendation 5: Expert Advisory Committee.

This White Paper will discuss the current state of Australian healthcare, why VBHC and VBP are solutions to a robust healthcare system, offer international examples and best practices, and set forth clear recommendations for implementation. Above all, this White Paper aims to ensure the medical technology sector are a part of the solution and seen as a collaborative partner with the massive headwinds facing Australian healthcare.

Table of Contents

Section 1: Introduction

This report is the narrative behind a 9-month program and research report written by Alira Health and commissioned by the Medical Technology Association of Australia (MTAA) Value-Based Procurement Group to understand and map the Australian VBHC landscape.

This report has a double purpose regarding the procurement of medical technologies in Australia. It aims to set the foundations for a policy change towards VBP for medical technologies ("top-down approach"), while setting the foundations for a Community of Practice in VBP implementation ("bottom-up approach"). For more information on this report, please contact the MTAA and/or Alira Health.

VBHC VS VBP: AN IMPORTANT NOTE AND CONTEXT

The reader will notice we have used the terms "Value Based Healthcare" (VBHC), and "Value Based Procurement" (VBP) somewhat interchangeably throughout this report. The rationale is due to the nature of the context in which they are used. Indeed, VBHC and VBP are intricately linked.

VBHC: this is defined as **the improved health outcomes for patients versus the total costs of delivering care**. Importantly, this is a patient-centric measurement, that spans the entire care pathway for a patient: from the time a patient enters a care pathway to the point at which they exit the care pathway.

VBP: across a VBHC care pathway, purchasing decisions need to be made. VBP represents the purchasing decisions across a VBHC care pathway. Spending may be determined by Policy Makers through a holistic budget or Payers who determine funding, coverage, and access in accordance with stakeholder input, and procurement purchases the items to actually deliver the care. All three are intricately linked, with the procurement decision often being the most critical decision points for the health technology the patient receives. Therefore, **VBP represents the purchasing decisions that consider the same health outcomes and total cost considerations as the VBHC care pathway**.

What is important is that VBHC, VBP and all the stakeholders involved are collaborating and engaging in a patient-centric manner, across the care continuum, and measuring consistent health outcomes and measurement of total costs. Currently this not happening in a structured way, but we are seeing a groundswell of initiatives to move towards a VBHC approach. Australia is no exception, the question is not whether VBHC, and by definition VBP, is appropriate, the question is how do we accelerate this.

One final note: many discussions have been had on whether procurement should define care pathway decisions, or care pathway decisions should define procurement. This somewhat misses the key point of VBHC and VBP: they should both be in collaborative dialogue to inform each other. Physicians and providers define the care pathway, payers, providers and procurement define the total costs associated with care. All stakeholders then define the appropriate value for their health ecosystem: how to improve health outcomes and how to balance the total costs of delivering care for patients.

VBHC represents the entire care pathway, VBP represents the purchasing decision across that care pathway. VBP is therefore a subset of VBHC, both are interlinked, and both require multistakeholder collaboration to fully deliver healthcare to Australians.

The report embeds five key themes, summarised below:

1. Healthcare systems are on the brink of a financial and operational crisis

Healthcare systems globally are on the brink of financial and operational unsustainability [1,36] The demand for healthcare is rapidly outpacing supply and the resilience to withstand future critical demand spikes (e.g., COVID) is uncertain. The Australian healthcare system is not immune to these pressures as demonstrated by increasingly limited access to care by underserved populations, high out-of-pocket costs, delays in accessing urgent care after hours, delayed information sharing across care settings, and long waiting lists for elective care. One of the primary causes are the extreme financial pressures on the healthcare system due to increased debt, worsening economic conditions, changing demographic factors and non-demographic factors. A systemic approach to addressing these challenges needs to be adopted. Pricing cutting and "quick-wins" will not solve the issues.

In April 2022, Australia had an estimated gross debt of $885.5 billion, the highest level since the 1950s and these debt levels are only being compounded by worsening economic conditions, including rising interest rates, and the highest level of inflation witnessed in generations.[4] At the state level, this dynamic is arguably most acute in Victoria, with a larger debt level in June 2022 than the combined total of NSW, Queensland and Tasmania in both nominal terms and as a share of gross state product. However, the gap is larger now than it is projected to be in June 2026.[7]

It is estimated that 5.1% of Australian healthcare spending is on medical technologies.[16] The remaining 94.9% is spent on the provision of care (hospitals, staff, and operational elements of healthcare), and pharmaceuticals. Cost containment measures set up in place by healthcare systems to combat the challenges described above only add to price pressures for medical technologies. Even with the most aggressive cost containment and cost-cutting measures on medical technologies, it will not come anywhere near to solving the issues. Rather, the estimated 5.1% of spending on medical technologies should be seen as an enabler to drive the efficiency gains in the remaining 94.9%. The move towards VBHC and VBP supports this. Alira Health, in collaboration with the MTAA has prepared a dedicated report that quantifies the difference the medical technology sector makes to the lives of Australian patients, the healthcare workers, the healthcare system and overall economy. The report is can also be considered in the context of the "Value of MedTech" report also produced by the MTAA. This report brings to light the significant value and contribution of medical technologies in Australia, particularly to Australia's healthcare system, industry development, employment and the wider economy.[22]

2. Medical technologies and value-based healthcare can be solutions to healthcare challenges

Value-based healthcare, and medical technologies present a viable solution to this dynamic. Value-based healthcare is a care-delivery model that measures health outcomes versus the total cost of delivering healthcare: it aims to improve both patient outcomes and healthcare efficiency. Value-based healthcare ensures the entire patient pathway is considered, with the patient at the centre of the equation.[1] Medical technologies often have benefit that continues to occur long after it is used, for example diagnostics, which impact up to 60 - 70% of all downstream decision making, or robotic surgery which can be seen as a platform that can concurrently serve multiple interventions and uses.

More specifically, across the patient pathway, procurement and purchasing decisions are made for services and medical technologies. Value-based procurement ensures health outcomes are the primary determinants for these purchasing and procurement decisions. If this happens, VBP and medical technologies can be a significant enabler to VBHC.[9,10] However, VBP is not holistically happening across Australia. This needs to change, and Australia needs to follow the lead of other countries/regions that are already experiencing success in VBHC and VBP. Examples include Canada, the European Union, England and Wales. [9,10,11,12,13,14,15] In these countries, and others, there are examples of how health outcomes have been improved, and total costs reduced. Given that approximately 70% of all medical technologies reach patients through some form of procurement decision, ensuring the correct procurement evaluation criteria is vital for the medical technologies sector.[9,10] There are challenges that emerge, including payment and funding risks, timeframes, outcomes measurement, cost calculations, and determining incremental improvement and savings associated with VBP. However, these challenges can be overcome through collaborative dialogue with all stakeholders.

3. An international movement towards value-based healthcare is well underway

Many countries have already initiated the shift towards value-based healthcare, AND, value-based procurement. There are numerous case studies, examples, and organisations to share knowledge on these pilot programs. Through the selection of five case studies on VBP from around the globe, we have highlighted how other countries have enjoyed success, which can be translated to the Australian context. [9,10,11,12,13,14,15]

Case Study 1 discusses the Value-Based Procurement Community of Practice in Europe. This was initiated in 2017 and designed to provide a networking platform for the exchange of expertise, experience, and initiatives. In fact, this is the thinking behind the recommendation for an Australian VBP Community of Practice. Founding members include leading procurement organisations, such as the European Health Public Procurement Alliance (EHPPA), and the European trade association; MedTech Europe. Several successful pilots have been undertaken and continue to be scaled up.[9,10]

Case Study 2 shows an infusion pump tender from the University Hospital in Sweden that clearly highlights how a technology with superior outcomes costs significantly less than a lower-priced alternative. It showcases with numbers how in VBP the most economically advantageous supplier can win a tender.[12]

Case Study 3 focusses on the journey and the learnings from a VBP tender for a faecal incontinence sacral nerve stimulation implant in Wales.[13]

Case Study 4 shows an overview of results obtained with VBP in cardiac care in Canada.[14]

Case Study 5 is an example from the National Health Service (NHS) in England regarding trays to avoid catheter-associated urinary tract infections. These trays were rolled out NHS-wide after a successful pilot in one hospital group.[15]

Levering an international example set, Australia could rapidly deploy value-based initiatives; however, the coalition of the willing partners needs to be established.

4. Collaborative dialogue and a multi-stakeholder approach is a requirement for success

Globally, and within Australia, financial and operational silos and hierarchies are one of the greatest challenges to healthcare reform. In order to successfully implement change, all stakeholders, including the medical technology sector, need to be included. Internationally, and within Australia, all stakeholders can be grouped into the categories shown in Figure 1. There are numerous sub-categories, but it is vital that the following groups are engaged in discussions on healthcare improvement:

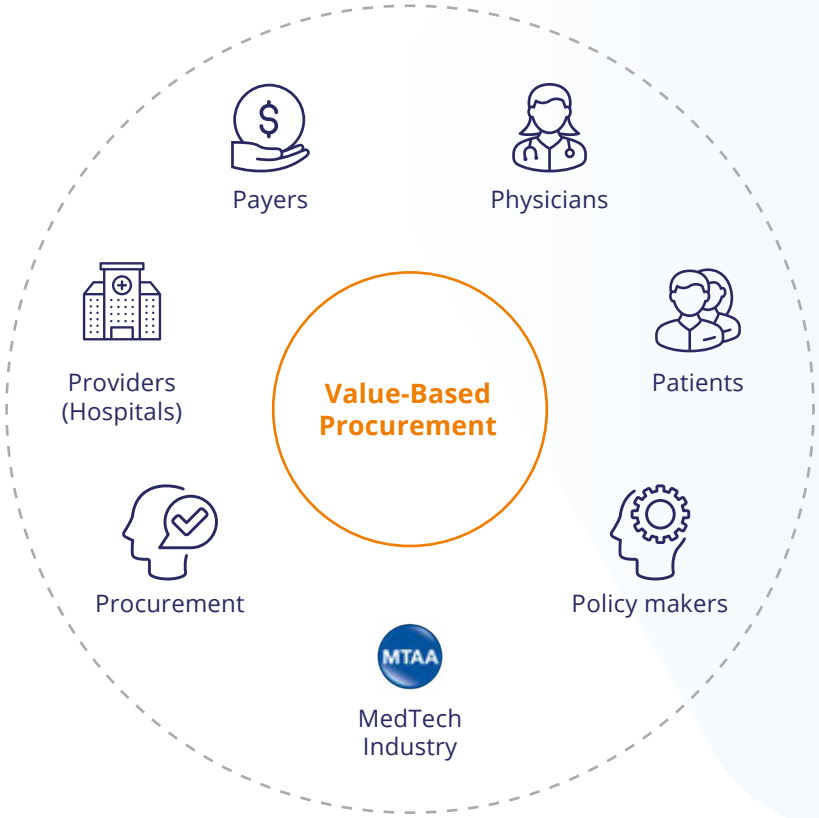


Figure 1. Stakeholder Groups Engaged in Discussions on Healthcare Improvement

1. **Policymakers:** VBHC and VBP can help to achieve policy goals, such as improved population health and reducing costs.
2. **Physicians:** Focus on outcomes in VBHC/VBP is aligned with how healthcare should be organised and helps physicians to focus on what matters most. Physician choice in technology selection is essential.
3. **Providers:** VBHC/VBP looks at the care continuum addressing care fragmentation. Opportunity to reduce costs, reduce waiting times, readmission rates and enhance manufacturer relations.
4. **Patients:** VBHC/VBP helps to increase high-quality, patient-centred care by aligning incentives with patient outcomes.
5. **Procurement:** Complicated procurement process with various criteria each with their values in different units.
6. **Payers:** Only pay for true value and outcomes, while reducing the spending on unnecessary or less effective care. Complicated role in translating requirements from all stakeholders in fair and transparent criteria.

This research report incorporates this multi-stakeholder approach.

An extensive deep dive, state-by-state, and stakeholder-by-stakeholder, to understand the VBHC and VBP landscape in Australia was undertaken through primary interviews and desk research. The willingness and readiness of Australian federal and state stakeholders to move forward on VBHC and VBP were assessed. Overall, the interviewees from the different stakeholder groups were broadly aligned on the following three items:

- **Long-term financial sustainability of the Australian healthcare system is at stake.**
- **There was broad alignment in VBHC as a solution.**
- **There was agreement on the strategic importance of the Medical Technology Sector.**

At the national level, the NHRA 2020-25, embeds language consistent with value-based healthcare. The NHRA 2020-2025 introduced six long-term health reform principles, of which two relate directly to value (Nationally Cohesive Health Technology Assessment and Paying for Value and Outcomes). Given the similarities, the role that VBP plays in purchasing decisions across a VBHC continuum, VBP would be highly supportive of the National Health Reform Agreement (NHRA) policy.[18]

Key findings from the research suggest that at the state level, the frontrunner regarding VBHC initiatives is New South Wales (NSW). However, concerns have been raised about the lack of medical technology sector input to NSW initiatives. Victoria has a globally renown VBHC approach with the Dental Health Services Program. In addition, VBHC is included in the Transport Accident Commission Strategy 2025, that has actively called for pilot programs. As well, Queensland has several initiatives regarding VBHC and a publicly shared example of VBP (see section 4). Interestingly, the disconnect between acute (public and private) and primary care systems and a lack of trust between stakeholders are critical barriers to VBHC implementation.

From a stakeholder perspective, VBHC is a frequent topic of discussion among those willing to move this forward, but despite the policy language at the national level there is no system-wide leadership commitment to a VBHC or VBP transformation. Moreover, VBP is significantly less well-known among the interviewees, and many felt VBHC initiatives were not related to VBP.

Regardless, Australia is well-placed for the shift towards VBP because it has mature procurement processes and frameworks. Where procurement in Australia, and many other developed countries, is significantly lacking is embedding improved health outcomes into the primary criteria for successful tenders. It is these health outcomes that should be the primary metric for health system performance. The majority of stakeholder interviewed agree with this approach, but a more robust tactical implementation ecosystem is needed.

5. Experts agree on VBHC and VBP implementation, although a strong "call to action" is needed

Experts interviewed have identified how the global healthcare challenges are relevant to Australia, and they generally agree that a more systemic measurement of improvement in health outcomes and total costs are essential going forward.

Alira Health has conducted interviews and found that Australian health stakeholders want to see VBHC implemented more in Australia, and that the Australian healthcare system has the systems and processes required to adopt VBHC and VBP but is currently missing critical pieces. Some key enablers, based on the desk research and validated by the expert interviews suggest the following for a way forward:

1. Establishing a Community of Practice to enable a knowledge transfer in VBP implementation.
2. Ensure a strong clinical input and alignment with VBP initiatives.
3. Enable a robust RWE environment and decision-making process.

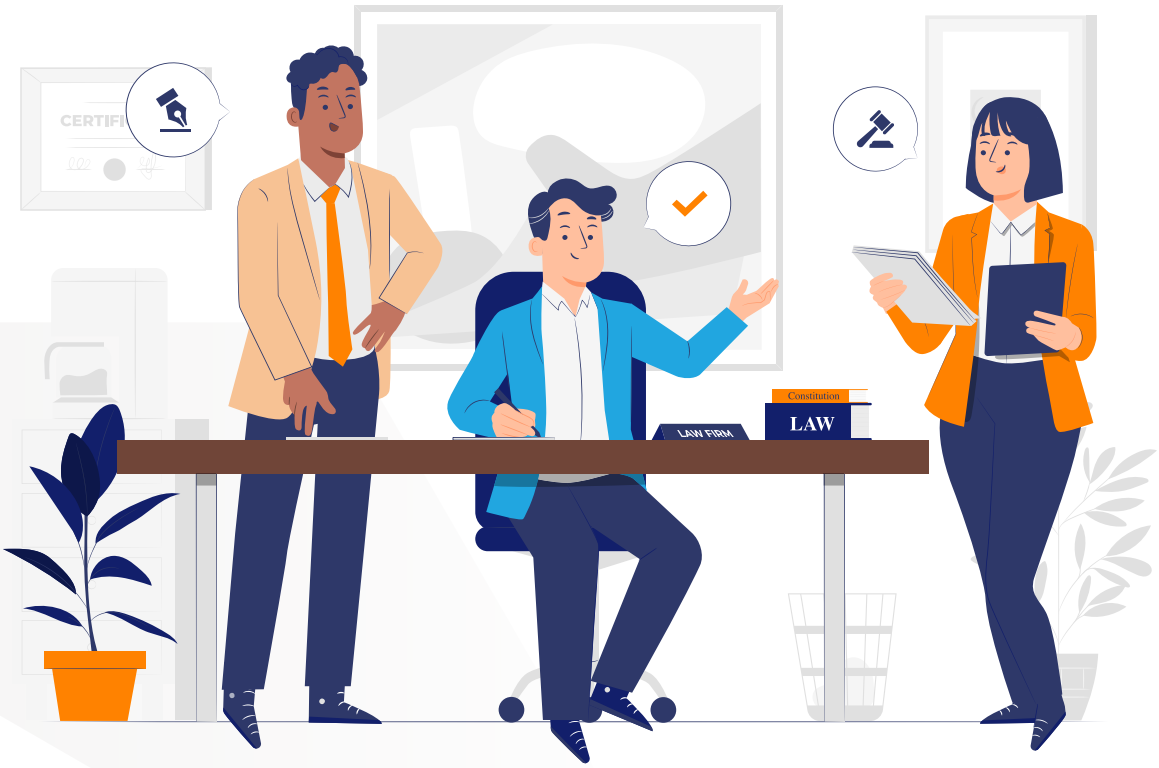
4. Link VBP initiatives to innovative payment models to appropriately incentivise stakeholders.

5. Establish an Expert Committee consisting of Australian and International thought leaders.

Other themes that emerged included the rapidly increasing role of environmental sustainability in healthcare procurement decisions. The linking of value-based initiatives to the health technology assessment (HTA) agenda and ensuring the considerations of Aboriginal and Torres Strait Islander populations in the prioritisation of healthcare reform.

Australia has a very strong HTA process, and is regarded alongside Canada and England in terms of robust methodologies. Therefore, there is a valid question about the role of HTA and VBHC in healthcare decision making. HTA can be defined as "a multidisciplinary process that uses explicit methods to determine the value of a health technology at different points of the lifecycle. The purpose is to inform decision making in order to promote an equitable, efficient, and high-quality health system.[35] Given this definition, HTA and VBHC can guide each other, but there are material differences that should be emphasised. HTA often provides an "economic" assessment, not an "accounting" driven one. HTA often looks at cost effectiveness and opportunity cost at a discrete point of the patient pathway or product lifecycle, and not the costs across the entire patient pathway as is the case for VBHC. However, where the two can support each other is in the similarities. Both VBHC and HTA attempt to measure some form of health outcome or cost, and both extend that measurement beyond just health outcomes and costs, to include societal value and lever physician input. Where healthcare arguably needs the most support, is across the silos and hierarchies of healthcare "accounting" and costing not the "economics" and opportunity costs of healthcare. By definition, procurement operates as a form of multi-criteria decision analysis (MCDA), levering concepts from more from an accounting perspective than an economic one. This makes procurement an ideal place to address healthcare costing challenges. Overall having some contribution of both perspectives certainly help in healthcare decision making.

To enable these strategic agendas, it is the strong recommendation of the MTAA and of organisations globally, that all stakeholder groups have a seat at the table. Ensuring patient outcomes are at the heart of healthcare decision making, with procurement included, would represent a major step forward in enabling these themes.



Section 2: Methodology for the Assessment of the Australian Value-Based Procurement Landscape

In January 2023, the MTAA commissioned Alira Health, a healthcare advisory firm, to conduct an extensive assessment of the Australian value-based procurement landscape. This project consisted of four modules. This project was initiated through the Procurement Working Group and had the two-fold objective of:

i. **VBHC & VBP Readiness:** Undertake a quantitative and qualitative assessment at the state and territory level that can provide a baseline assessment to engage in VBHC and VBP initiatives.

ii. **Solution-driven Recommendations:** Lever the quantitative and qualitative research as a foundation for the creation of strategic recommendations on how to expand the implementation of VBHC and VBP initiatives. These recommendations have the higher purpose of ensuring industry participants are part of the solution in rectifying the challenges facing Australian healthcare and represent a call to action for collaborative dialogue across all stakeholder groups.

Module 1 aligned all participants of the MTAA Value Based Procurement Working Group on the objectives and direction of the research and to aggregate the existing knowledge base on VBHC and VBP across Australia. Module 2 expanded this knowledge base through extensive desk research, and included a more robust assessment across each of the six stakeholder groups. Module 3 conducted expert interviews that followed a structured interview guide and validated both the member input and desk research. Module 4 synthesised the desk research and expert interviews into a set of strategic recommendations, background research report, and this White Paper. It is intended that the findings of this assessment be presented and shared at external conferences and meetings.

Alira Health has conducted this research by levering a proprietary value framework that incorporates the findings of expert interviews to share perspectives of the key stakeholder groups. Specifically, these stakeholder groups can be further sub-divided, but can be aggregated as the 6 P's:

1. **Physicians:** Doctors, nurses, clinicians and experts delivering individual care to patients.
2. **Providers** (hospitals and hospital groups): the facilities providing the place of care.
3. **Payers:** individuals and organisations paying for the care.
4. **Policy Makers:** individuals providing the policy frameworks to enable the decision frameworks for access.
5. **Procurement:** individuals determining what services and solutions are paid for based on tender criteria, often with a provider- or payer-defined budget.
6. **Patients:** individuals for whom healthcare systems are designed for and benefit from care.

An important consideration for the methodology of this project, and forming the proposed recommendations, is that it is broadly acknowledged that healthcare systems globally are broken. Systems need a rethink. The recurring challenges of organisational hierarchies and silos, both clinically and financially, represent a material challenge to improving healthcare. They are a recurring challenge.

A major goal of this assessment is to ensure that industry is seen to be part of the solution to resolving Australian healthcare. Being part of the solution includes seeking objective input from all key stakeholder groups, across all states and territories, and the modus operandi moving forward is collaborative dialogue. This is an essential foundation for all stakeholders to consider if Australian healthcare is to be rectified. No single stakeholder can do this alone, and industry representatives are prepared to play an active role. Therefore, a core methodology embedded in this White Paper is that all stakeholders across all participating states and territories have a voice and are included. This White Paper aims to foster a culture of trust and collaboration to ensure all stakeholders are focused on improving health outcomes for patients and improving the efficiency of healthcare delivery.

Section 3: Statement of Issues and Solution (Global and Australia)

Healthcare systems globally are under immense pressure to deliver on their mandate of ensuring the health of the populations they serve. Demographics and morbidity criteria alone have led to a massive imbalance between healthcare demand and supply. Factor in the legacy stress and burnout placed on healthcare workers and health systems due to the COVID 19 pandemic, and there is a supply-demand imbalance that could have consequences far beyond the healthcare sector. The great challenge for healthcare systems is to meet the increased demands of healthcare consumers in a fiscally constrained environment. This worsening supply and demand imbalance is the core of the issue. The result are healthcare systems globally that are on the brink of financial and operational unsustainability. Australia is no exception to this dynamic.

The Australian healthcare system is generally recognised as one of the best in the world. It is based on the Beveridge model which emphasises tax-funded healthcare and equality for citizens. From a funding perspective, the Australian healthcare system is based on a complex structure of funding arrangements through the national, state, and territory governments . National and state government funding supports the majority of healthcare, including 80% of hospitals and 62% of primary health expenditures.[3] In Australia, the private healthcare system is very robust and serves a large portion of the population. According to APRA figures, as of December 2022, 45.1% of Australians (11.86 million people) have private hospital cover. 55.1% of Australians (14.41 million people) have private extras cover. An estimated total of $19.1 billion was spent on private hospitals in 2020-2021.[19]

From an outcomes and expenditure perspective, the average life expectancy is 83.2 years, with health spending equating to 10.2% of the GDP. This places Australia 11 out of 38 of the OECD countries and above the median healthcare spend of 8.05% GDP.[2,3,6] Australia achieves these outcomes cost-effectively when compared with many of its counterparts. An overview of the health spending flows can be seen in Figure 2.

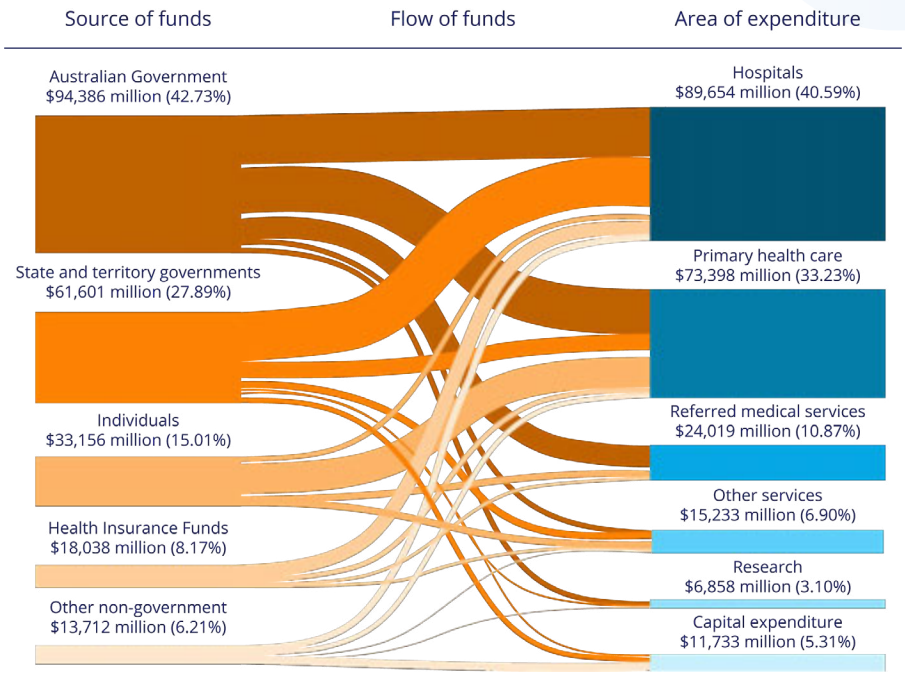


Figure 2. Broad Health Spending Flows (2020-2021) – AIHW Health Expenditure Database[6]

Despite this high OECD ranking, the Australian healthcare system is not immune to the fundamental supply and demand pressures experienced globally. These pressures materialise as limited access to healthcare, high out-of-pocket costs, delays in accessing urgent care after hours, delayed information sharing and long waiting lists for elective care.[17]

Funding levels and financial pressures on healthcare are exasperated by increased debt (Australia had an estimated gross debit of AUD885.5 billion in April 2022, the highest level since the 1950s)[4], worsening economic conditions (e.g. growing interest rates, an 11-year high was reached in June 2023[20], and 7% inflation[21]), and changing demographic factors (e.g. aging population, increased prevalence of chronic disease) and non-demographic factors (e.g. increased healthcare consumption).

A mix of annual spending caps that is lower for low-income individuals intended to address income-related equity has resulted in cost-related access problems for higher-income residents.[34] Informational asymmetry between patients and health service providers has also made coordinating patient care difficult and hampered efficiency. With a strong demographic case for increasing healthcare spending, but hampered by widespread inefficiencies, maintaining the current level of healthcare and improving it over the next decade will present major obstacles.

Another cause is the inefficiencies in the healthcare system. The ACQSHC, for example, found over 330,000 potentially preventable hospitalisations from 2017 to 2018, with massive variations in rates across Australian regions. [8] Inefficiencies arise from limited integration of pathways of care and are exacerbated by fragmented funding between primary and secondary care. There is growing concern among policy makers, providers, and academia that the Australian healthcare system in its present form is unsustainable. This is even more extreme in the underserved indigenous communities. As discussed by Prof. Cutler et. Al., there is a concern among policymakers, providers, and academia that the Australian healthcare system as it currently runs is not sustainable.[17]

> *Despite the universal health system in Australia, there are a lot of inequities in access and outcomes, particularly for the indigenous population."*
>
> **Christobel Saunders,**
> ***Professor, Head of the Department of Surgery***

Medical technologies have a key role to play in managing these inefficiencies. Medical technologies play a vital role among all stages of disease: prevention, screening, diagnosis, treatment/intervention and follow-up. Medical technologies bring value in the organisation of care and provide broad social benefits (e.g., patient advocacy, environment and sustainability initiatives, etc.). In Australia, 17,000 people are employed directly for medical technology-related work and the contribution of the industry to the GDP was AUD5.4 billion (in 2021 and 2022).[22]

In 2020 and 2021, Australia spent a total of AUD220.9 billion on healthcare.[3] It is estimated that approximately 5.1% of healthcare spending goes to medical technologies.[6] The remaining 94.9% is spent on other areas of healthcare, including basic operational provision of care, including hospitals, staff, pharmaceuticals and service provision. The spending on medical technologies is a relatively small percentage of the entire equation and yet, receives immense price pressure from procurement bodies. Given that a significant portion of healthcare innovation comes from medical technologies, such price pressure can begin to impact innovation. The NHS in England has clearly articulated that prices can only go so low before the savings are not material, and innovation for patients suffers. Even with the most aggressive cost containment, cost cutting on medical technologies will not solve the issues. Rather, the narrative should be that the right spending in the 5.1 % medical device budget can help drive efficiency gains in the remaining 94.9%. The move towards VBP aims to help procurement identify this right spending.

When we look outside of Australia there are some significant VBHC and VBP learnings that can be gleaned. Levering the international experience highlights examples that Australia can use to mitigate the extreme risks healthcare is facing. Some examples are listed below.

Five International Examples of Value-Based Procurement:

Case Study 1: The VBP in CoP In Europe[9,10]

In 2017, MedTech Europe initiated a VBP CoP that was designed to embed clinical and economic outcomes more fully into the healthcare procurement process.[9,10] This community of practice provides a networking platform for an exchange of expertise, experience, and initiatives. Along with leading procurement organisations, such as the EHPPA, MedTech Europe are founding members. Several successful pilots have been undertaken and continue to be scaled. Some systems, such as the NHS in England have mandated that their entire supply chain include health-related outcomes and employ non-price driven tenders.[11] Other health systems such as the Hospital Clinic in Barcelona, the NHS in Wales, the Charité in Germany, and L'Assistance publique-hôpitaux de Paris (AP-HP) in France, all have dedicated multi-stakeholder teams to enable VBHC delivery models.

Similar to the NHRA and Commonwealth Procurement Rules (CPRs) in Australia, the European Directive 2014/24/EU was introduced in 2014. This provided the Most Economically Advantageous Tender (MEAT) policy framework to enable procurement decisions that were considered across the produce life cycle, and not price only. Australia, using its own policy language, can enable a similar approach. The MedTech Europe CoP used this as a foundation for ensuring a VBP approach.

Using this policy foundation, the VBP CoP members and the partner organizations conduct various activities detailed further in Figure 3:

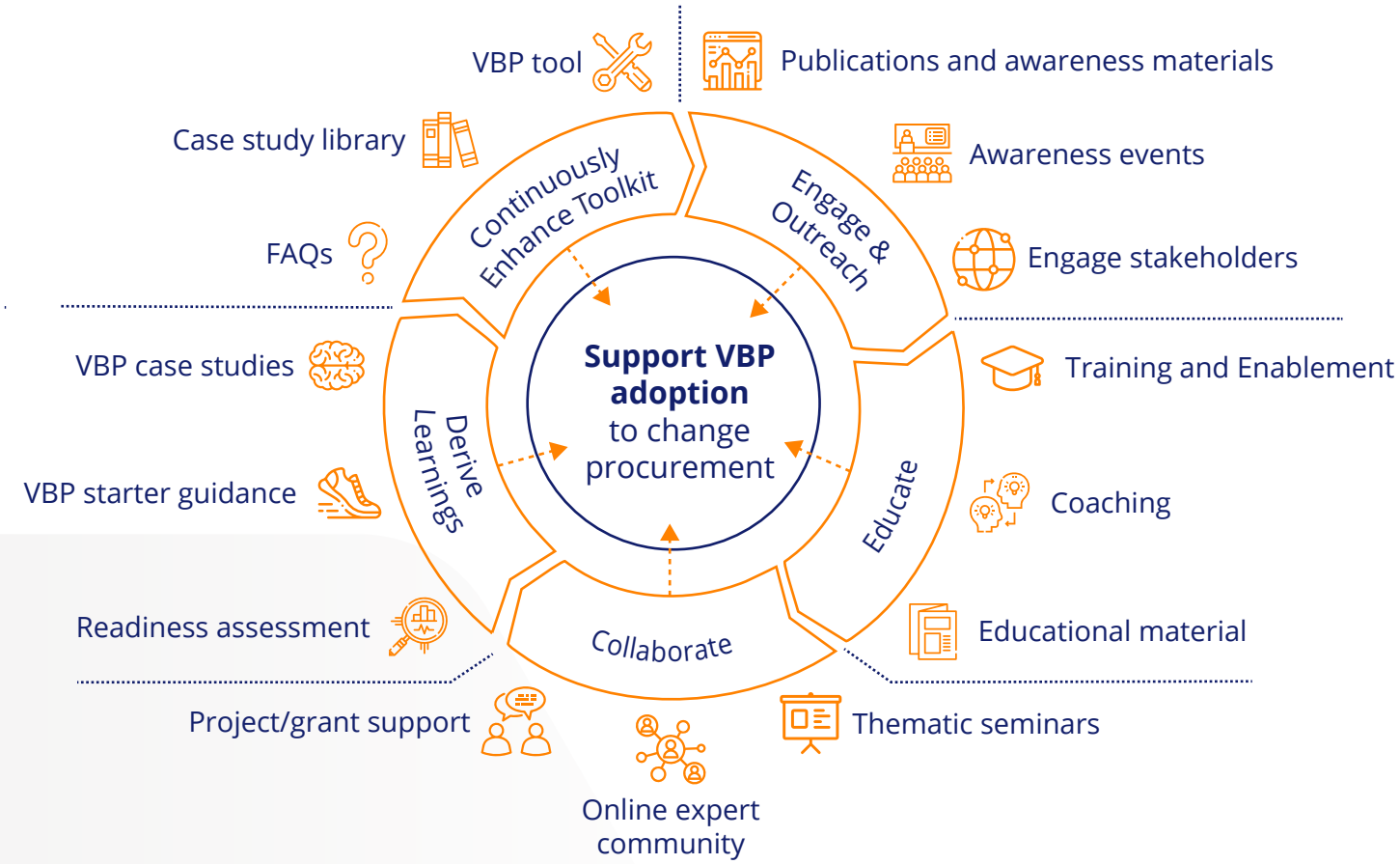


Figure 3. Activities by the VBP Community of Practice in Europe

For several years, the European Commission has been exploring the potential of VBP as a tool for increasing the financial sustainability of healthcare systems. Since the adoption of the new Guidance on Public Procurement for Europe in 2018, there have been various initiatives looking at how VBP can:

- Increase the integration of innovative solutions in healthcare systems.
- Accelerate research and innovation in areas of pressing healthcare urgency.
- Improve European regions' investments in healthcare.
- Respond to the new questions arising from the impact of healthcare on the environment.
- Initiate new healthcare opportunities through the opening of public procurement markets outside of Europe.
- Enhance small and mid-size enterprise participation in public procurement.

Through this CoP, various pilots on VBP have been undertaken. These have demonstrated that VBP can bring benefits across four domains:

1. Outcome-Driven Approach: Focus is on optimising outcomes, rather than more short-term price/volume discussions. Data collection behind the outcomes as a backbone for continuous evaluation and improvement. An example is in a region of Southern Denmark that started risk-sharing around patient outcomes when purchasing knee replacements. This led to reduced patient hospitalisations, reduced readmissions 30 days after discharge and improved patient-reported outcome measures (PROMs) 1 year after surgery.

2. Patient-Centric: The focus is on select suppliers that prioritise patient needs and preference as measured by the impact on patients. Examples include the Netherlands where Zilveren Kruis procured fully integrated solutions for cataract care. This led to reduced total cost of care and a better patient experience. There are also regional examples across countries in Europe, including RITMOCORE, a Public Procurement of Innovation (PPI) project by the EU. This moves away from conventional purchasing of devices (pacemakers) to an innovative service provision. This has led to a significant increase in telemonitoring.

3. Cost-Effective: Pricing and cost are a critical component of VBHC and VBP. However, instead of a relentless focus on just price, pilots encompassing cost effectiveness considered the total care pathway and long-term costs. This led to optimised resource allocation through procuring the right solution for the desired outcomes across the care continuum. Examples in the United Kingdom include England, where there are multiple examples in the English NHS where reduced hospitalisation rates (cardiac), overnight stays (parotid surgery), operating and recovery time (urology), patient flow, infections, and variations were considered. Longer-term cost avoidance, not only cost minimisation, were considered in the procurement process. In addition, in NHS Wales, where anticoagulant point-of-care tests were procured through an open procedure leading to reduced emergency room admissions.

4. Discussion around holistic value including health system value: Value discussions were conducted that incorporated clinical outcomes, quality, safety, patient preference, clinician preference, sustainability, and cost, which was already a big step forward. However, this was taken even further to include system value. An example was in Norway where VBP was used to break-up a high concentration of orthopaedic suppliers. Three suppliers were selected per sub-category. This helped hospital providers keep flexibility on pricing, while enabling more suppliers to aggregate Real World Data (RWD).

Relevance for Australia

This is a clear example of where a legislative need drives a multistakeholder change in healthcare. Levering multistakeholder best practices, and supported by industry, the MEAT procurement directive in Europe was adopted and turned into a value framework for discussion with stakeholders. Health outcomes were put at the centre of the procurement process, and system-wide value was created. This is what Australia can replicate through the NHRA, possibly the CRP, and can be driven by a multistakeholder Community of Practice.

Case Study 2 in Sweden: Example of a University Hospital Infusion Pump Tender[12]

Background

In 2018, the Karolinska University Hospital in Sweden took a willingness-to-pay approach to tendering for infusion pumps. The infusion system supports optimised patient flows and working methods, and ensures high quality and patient benefit. One of the objectives was to choose a supplier as a long-term innovation partner.

Objectives with a VBP model

Karolinska University, a leader in VBHC implementation was seeking to ensure patient safety was a key outcome criterion for the procurement decisions. This included factoring elements far beyond price and included a service provision from the manufacturers and healthcare professional (HCP) usability and ergonomics. Technical specifications were added, including special functions, system settings and a power supply.

VBP Mechanism:

Three suppliers met the original screening requirements; however, only two were selected to bid due to certain technical requirements. Therefore, only two suppliers were bidding on the tender. For each technical criteria NOT met, a monetary value was ADDED to the total cost of the procurement value. The technology with the highest value was then eliminated.

VBP Outcomes:

The supplier that satisfied all the requirements was then selected. This was despite the fact the manufacturer with the highest raw equipment cost by a significant margin was selected, as the TOTAL costs were dramatically lower. This is a very clear example of how “cost” and “value” can vary materially when considering individual products instead of the entire product life cycle. This is arguably one of the clearest examples of incorporating patient outcomes and patient safety into a procurement decision.

Relevance to Australia:

Australian hospitals face similar challenges as the Karolinska University hospital and could set-up a similar procurement model. In this instance it is a clear methodology in which Australian hospitals can rapidly implement a global example of procurement that is not price only. For more information on the case study, please visit the Karolinska Institute website. [12, 38]

Case Study 3 in Wales: Journey of a Faecal Incontinence Sacral Nerve Stimulation VBP Pilot[13]

Background

Wales is a global leader in holistic VBHC implementation, and likewise for VBP. An example is in the Faecal Incontinence Sacral Nerve Stimulation technology. In Wales, a risk-sharing agreement was discussed with clinicians, the manufacturer, and procurement whereby an agreed minimum improvement in reduced episodes, and an increased quality of life (QoL) was necessary for payment. A zero payment was made if a minimum improvement level was not substantiated with evidence. If there was evidence to suggest improvement, this would trigger a payment 12 months after implant.

Results with the VBP Model

The results of this pilot led to improved health outcomes, as measured by:

i. The number of incontinence episodes per week: Following permanent implantation, 47% to 75% of participants achieved at least a 50% reduction in the number of faecal incontinence (FI) episodes per week.

ii. The International Consultation on Incontinence Questionnaire: a psychometrically robust, self-report instrument for the evaluation of faecal incontinence and its impact on QoL. The evidence suggested a mean reduction of ≥2.0 across the three domain scores.

iii. Rockwood faecal incontinence QoL questionnaire: subscales were measured including: lifestyle, coping/behaviour, depression/self-perception, and embarrassment. The evidence suggested an improvement in overall score of ≥0.4.

iv. Patient treatment satisfaction questions: Patients were asked if they would have this treatment again and if they would recommend this treatment to others. Evidence demonstrated that patients answered "yes" to both questions.

Pilot Evaluation

Success was demonstrated through patient engagement and feedback, clinical drive and support, supplier willingness to share the risk, procurement expertise and value focus. Areas for improvement included mapping and costing data being difficult to collect, a paper-based patient diary and PROMs, delays in sign-offs for the business case, and other administrative burdens. Key learnings are that the clinical and patient benefit were undoubtedly a success; however, operationally and administratively there are areas for improvement. Moreover, early clinical and financial engagement is key, investment versus cost, power and insight of patient perspective and insights.

Relevance to Australia

This example was conducted by a global leader in VBHC implementation, Wales. The pilot ensures that it is the health outcomes that are paid for, not just the technology. This is done via a form of risk-sharing agreement and value-based contract, something Australia has had a call to action to implement[37].

Case Study 4 in Canada: Cardiac Care in Ontario[14]

Background

A pilot in Canada was started in 2015 when Supply Chain Ontario was awarded funding to Southlake Hospital to implement innovative solutions to improve health outcomes while maximising value in cardiac care. Similar to the Karolinska University example, investment decisions were based on overall value to the hospital and health system, patient outcomes, increased access to the latest innovation, and innovative supplier initiatives. This is a clear contrast to the traditional costs only approach for a specific product or service.

Initiative Outcomes

The initiatives outcomes are demonstrated in Figure 4.

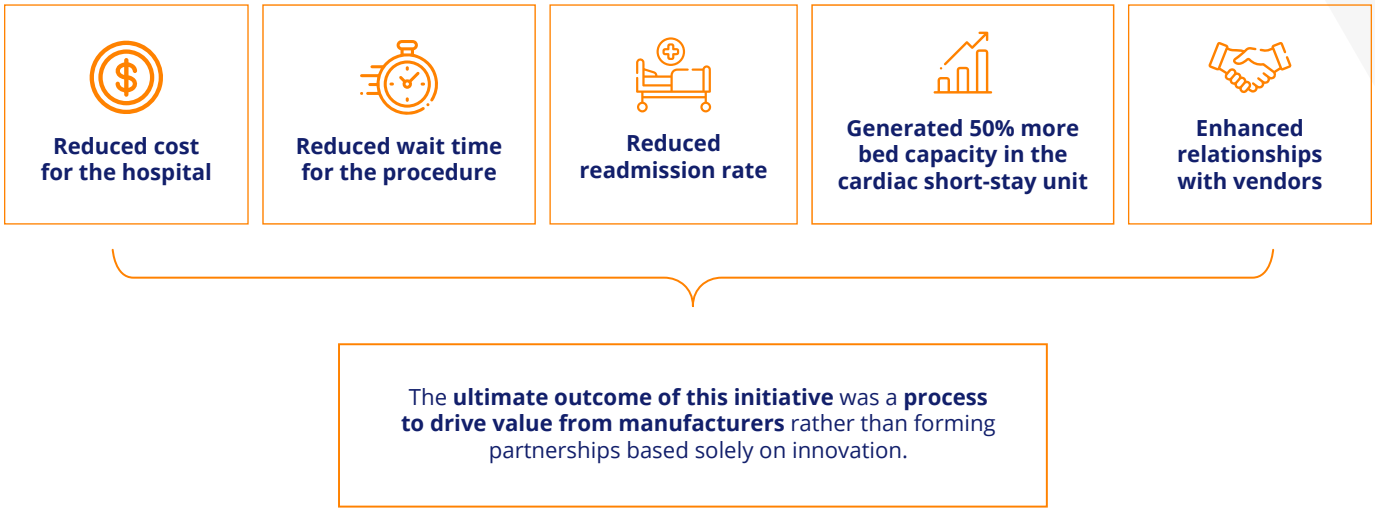
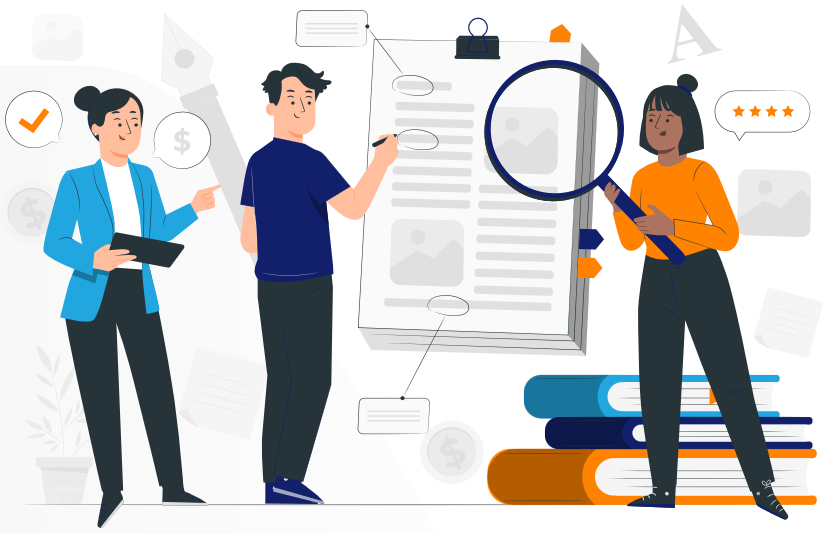


Figure 4. Initiative Outcomes

Relevance to Australia:

The objectives of the pilot in Canada are to extract value for the system, instead of only innovation, a fair goal. Given the holistic value medical technologies can play in the healthcare ecosystem, this is an example where value beyond innovation can be levered.



Case Study 5 in England: VBP Urinary Tract Infection Pilot in the North Midlands[15]

Background

In England, and globally, catheter-associated urinary tract infections (CAUTIs) are quite common and can cause patients significant pain, discomfort, confusion and anxiety for family and friends. This has downstream impacts on healthcare system utilisation due to increased antibiotic use, prolonged hospital stays, increased clinical activity and risk of complaints and litigation. In 2019, the University Hospitals of North Midlands NHS Trust audited its urethral catheterisation practice and the way patients were cared for in clinical areas. The audit highlighted a wide variation in care delivery leading to inconsistent outcomes for patients and staff.

Initiative

The manufacturer technology for urinary catheter contains all the essential items to (re)catheterise a patient in one pack and includes the catheter with a pre-connected urine drainage bag. This unique "closed system" prevents ingress of bacteria and helps avoid catheter-related infections. The supplier worked collaboratively with the University Hospitals, to identify and build evidence around how a change in practice can improve patient care and achieve savings. The introduction of the all-in-one system was supported by supplier training and an audit that enables clinicians to easily follow the best clinical practice in the catheterisation and management of patients with Foley catheters.

Results with the VBP Model

As a result of this pilot, catheter-related infection rates fell by 80% at the pilot site. Patient experience improvements included a reduction in complaints, a reduced length of stay, a reduction in catheter-associated urinary tract infections and a reduced likelihood of patient urethral meatus trauma. Moreover, clinicians reported that the pack was intuitive and saved approximately 5 minutes per catheterization, which during the pilot process, meant over 83 hours for 1,000 catheterization procedures. The key outcome was that the technology was further rolled out in the NHS England after this pilot, based on improved health outcomes which is the real value for patients. The initiatives outcomes are demonstrated in Figure 5.

Figure 5. Initiative Outcomes

The Australian healthcare system is experiencing significant challenges, as evidenced by the fiscal and operational challenges highlighted. Many of these challenges can be resolved when taking best practices from international examples in VBHC and VBP. Australia can implement the changes, it now needs the associated shift in mindset to overcome the silos and hierarchies, collaborate across stakeholder groups, and begin to implement holistic change. The MTAA would welcome this shift and would support initiatives improving health outcomes and lowering total system costs.

Section 4: Summary of the Australian Desk Research and Expert Interviews

Value-based healthcare and value-based procurement are well discussed concepts. In fact, many feel the terms to be a cliché at this stage. This goal of this White Paper is to avoid this stigma. One of the primary ways to avoid this was to do an extensive baseline of VBHC and VBP readiness across each Australian state and territory, and then validate the findings with expert interviews. This section will discuss the key themes and findings of the desk research and the expert interviews that were conducted.

The MTAA, in collaboration with industry participants, commissioned Alira Health to undertake an extensive deep dive, state-by-state, and stakeholder-by-stakeholder, to understand the VBHC and VBP landscape. Alira Health reached out to 160+ individuals/organizations from different states and stakeholder groups in Australia with a personalized email. An overview of the included stakeholders and states are given in Figure 6; industry participants are not included in the left figure showing the state/territory distribution.

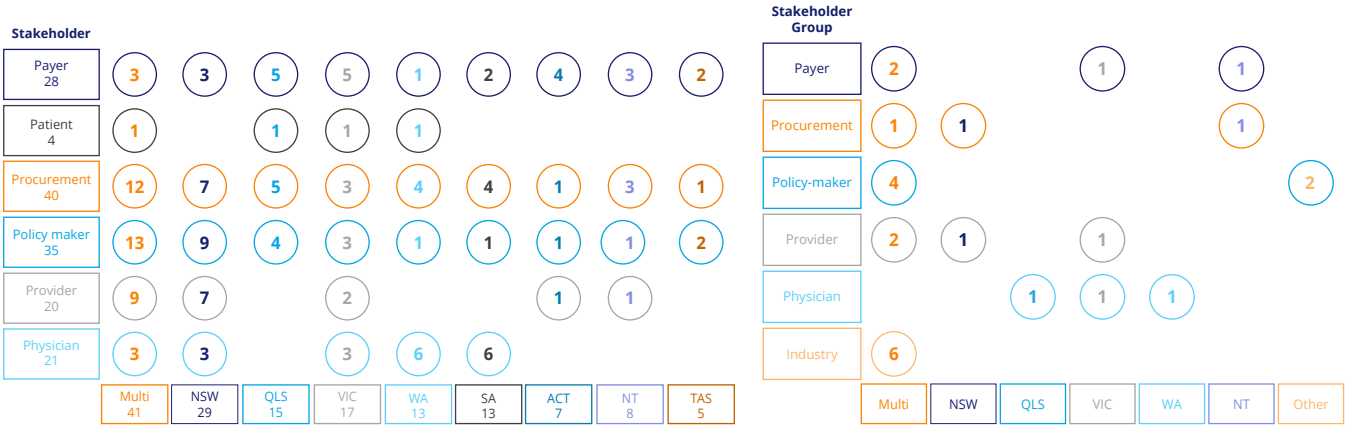


Figure 6. Overview Interview Outreach and Completed Interviews

26 interviews (including industry) were conducted during this project, with nearly 160 stakeholders contacted.

These figures are interesting in that those that were interviewed were very supportive of VBP. However, this VBP advocacy has not yet taken hold in Australia. We expect significantly higher response rates as the success of VBHC initiatives grow and are shared. As highlighted in the methodology, the objective of these interviews was to engage with key stakeholders across diverse groups, including physicians, providers, payers, policy makers, procurement officials and industry representatives. Of note, many stakeholders who were contacted did not feel their initiatives were VBHC or did not feel ready to discuss. Time constraints, lack of familiarity with the topic or complexity of the value-based terminology could have played a role here. However, given their programs were designed to improve outcomes, improve the efficiency of the system, indicates there is significant misunderstanding of each stakeholder role in the VBHC ecosystem. A top-down approach towards value-based healthcare and value-based procurement implementation can help clarify this misunderstanding.

It is acknowledged that selection bias may exist with respect to the interviewed candidates, as those not wishing to engage with industry may not have accepted invitations to contribute.

From this outreach, 26 interviews were conducted for this project, from various roles and states. Interviews also spanned both public and private healthcare stakeholders. We have aggregated the findings into two main categories: by stakeholder and by level of government.

Findings by Stakeholder Group

Overall, the interviewees from the different stakeholder groups were broadly aligned on the following three items:

1. Long-term financial sustainability of the Australian healthcare system is at stake. The model is currently funding volume (not enough value), and various inefficiencies need to be addressed. The healthcare system is complex, with many stakeholders involved through fragmented budget models and siloes. Changes that add value across the health system may be delayed or even stopped as costs and decisions reside in a single budget different from where the value is obtained.

2. Broad alignment on the concept of VBHC. The VBHC model can help the various stakeholders to align around value while limiting costs paid by taxpayers and patients. There is the need for clearer definitions around value, VBHC and VBP to have an agreed and consistent direction for these multidisciplinary engagements. Engagements in pilots are possible at a local individual basis, but a strong Commonwealth push for the value-based agenda is unlikely.

3. Most participants agreed on the importance of Industry. Industry is a long-term partner in providing value to patients and the other healthcare stakeholders. Industry is bound by commercial imperatives but run by patients. Increased trust and transparency between industry and the other stakeholders is needed. This can be obtained through more value capturing, messaging, and sharing. Data collection (including RWD) will play a vital role in this. It is acknowledged that selection bias may exist, as those not wishing to engage with industry may not have accepted invitations to contribute.

The key interview findings per stakeholder group are summarised in Table 1, together with the number of persons interviewed per stakeholder group:

Table 1. Key interview findings per stakeholder group

Physicians (3):	**Providers (4):**
1. Fear that VBHC would turn out to be a funding or control mechanism. Little willingness to be evaluated on outcomes.	1. Willing to have more discussions around value as patients are coming in unnecessarily or (too) late. Need for systematic changes to the system.
2. Believe that big advances in the medium term will come from improvements in the healthcare systems. Request for more RWD on the value of medical devices to see their impact.	2. Increasingly looking at patient and other outcomes when making procurement, staffing and other organisational decisions.
3. It is the value-based payments and Procurement models that need the work, less so the clinical pathways.	3. Feel like they have little control over the levers to drive towards VBHC. Prevention often occurs outside their remit and physicians/surgeons often not employees.

Payers (4):

1. Drivers to have more value discussions are the variation in care and patients receiving low value care too often (e.g., over utilisation of certain procedures).
2. Willing to pilot VBP, e.g. through a fund based on savings from price decreases. Especially willing to support getting innovative technologies faster to market.
3. To look at value beyond budget cycles and cost-saving KPIs; support from the executive level will be required.

Policy makers (6):

1. Supporting the value-based transition through research and policy work.
2. The Funding Medicare Report described how to move care out of the hospitals into the community, prevention, and multidisciplinary approaches.
3. The government is looking for efficiencies and improving outcomes. Facing significant workforce shortage issues that are unlikely to be resolved soon. VBHC thinking will be part of the solution.

Procurement teams (3):

1. Still driven by annual budget cycles and cost containment KPIs. Little experience or flexibility with non-standard procurement processes.
2. For larger procurement decisions, discussions are split over different panels (clinical, economical, operational or IT/technical/interoperability), with a super panel making the final decision.
3. Greenfield versus Brownfield investment decisions. These budget discussions usually happen outside of the procurement bodies.

Patients:

1. Need for a patient identifier that follows patients over the total care pathway.
2. Need for more transparency over the full cost of the treatment and out-of-pocket costs. Value-based thinking can help in collecting this data.
3. Need for more outcomes and follow-up data. Complication rates, unplanned readmissions, length of stay, transfer rates to ICU, rehabilitation over periods of time (e.g., 90 days after a hip surgery) are often missing.

**Due to privacy and unique considerations, the perspective of patients was not directly included. This was done through the stakeholder groups indirectly. Patient/consumer groups will be recontacted in later stages.*

Industry (6):

1. Customer (both patients and staff) relations are being transformed from transactional (product and price focussed) to a genuine partnership with the industry as a critical enabler of delivering value (tools, services, and outcomes). Co-design with customers is key. Providing solutions to customers and their patients that are based on value-for-money instead of focusing on the lowest possible sell price.
2. Will be suspicious of tender processes focusing on outcomes rather than products/price because it may appear to create an unfair advantage to some suppliers. The expectation that equitable opportunity for all companies to respond to a tender will remain, not to exclude local or smaller companies through tender specifications. For any change, it is key to consider facilitating a competitive landscape.
3. Industry can help by having technologies go through HTA assessments (where relevant), having a clear value defined, and having the proper data on patient-reported outcome measures and other outcomes to see how the technology affects patients more than just the cost to the hospital or system.

VBHC is everyone's responsibility. Everyone needs to engage around a common purpose."
Kylie Woolcock, ***CEO Australian Healthcare and Hospitals Association***

The desk research and interviews captured various initiatives, frameworks, pilots with a value-based element at both the federal, state, and territory level. The results were consistently supportive of the value-based care delivery model. The largest concern from most stakeholders was that scaling up the pilots can present significant administrative and operational challenges. On a state-by-state basis, various initiatives were identified, but there remains much work to do before the holistic adoption of VBHC and VBP.

Findings by Level of Government

NATIONAL LEVEL

Similar to the EU Directive in Europe, in the last NHRA, specific language was included to highlight the measurement of health outcomes and purchasing based on "value" in Australia.[18] All Australian states and territories have agreed to move towards value-based care through the Addendum to the NHRA 2020-25. The NHRA 2020-2025 introduced six long-term health reform principles, of which two relate directly to value (Nationally Cohesive Health Technology Assessment, Paying for Value and Outcomes), two enable greater value in the system, and two aim at improving population health. The Paying for Value and Outcomes reform seeks to enable new and flexible ways for governments to pay for health services, by creating stronger financial incentives to improve patient health outcomes and patient equity through best-practice care, delivered within a more coordinated and integrated way. The Long-term Health Reform Agreement outlines a pathway toward achieving these reforms. The Paying for Outcomes and Value reform will start by developing a National Health Funding and Payments Framework, seek to remove legislative, regulatory, and technical barriers to funding reform, and trail and evaluate new funding models by the end of 2024-2025. Given the similarities, VBP could be part of the NHRA pilots.

The CPRs are a set of rules published by the Australian Government and are used, e.g., for the national stockpile and the national diabetes service scheme.[23] The CPR does not mention outcome measurement but does include whole-life costs and non-financial costs when making procurement decisions. While these CPR rules include some value-based terminology, as highlighted by some interviewees, these rules are rarely used for medical technology procurement.

STATE & TERRITORY LEVEL

New South Wales: Frontrunner regarding VBHC thinking and implementation among the Australian states and territories. Value-based thinking and initiatives are common and often clinician focused. Examples are: Leading Better Value Care, a value-based healthcare framework, Integrated Care, Commission for Better Value, a state-wide initiative for diabetes management and a publicly communicated VBP contract for hip and knee replacement.

> *Collaborative commissioning in NSW is the closest to VBP I have seen in Australia. NSW has a clear value agenda."*
>
> **Sigrid Patterson,**
> ***Director of People, Planning and Performance at Healthy North Coast***

Victoria: Has a globally renown VBHC project with the Dental Health Services Program. The VBHC is also included in the Transport Accident Commission Strategy 2025. HealthLinks, a VBHC pilot project, has been completed with valuable learnings. Broader alignment that the VBHC is the way to go needed among various stakeholders.

> *Victoria has moved towards a more centralised procurement system. Being a bigger customer on behalf of the health system is one way to advance value. I also think that working with clinicians is critical, to get them to understand that choices and high-value decisions impact their patients and the HC system."*
>
> **Andrew Wilson,**
> ***Chief Medical Officer at Safer Care Victoria***

Queensland: There are several initiatives in VBHC as well as a publicly shared example of VBP (see section 4). Initiatives such as the Queensland Health 10-year Research Strategy can be supportive to VBP.[24] The Allied Health Service in Queensland has a VBHC framework.[25] Other initiatives are the Promoting Value-Based Emergency Department (Prov-ED) and Getting it Right First Time (GIRFT) programs.[26,27]

South Australia: Few initiatives were identified, although there was some terminology and pilot programs identified in South Australia. The exception is the state-wide initiative to collect patient-reported measures, scheduled to launch in mid-2023.[28]

Western Australia: VBHC and VBP are mentioned in policy recommendations such as the Sustainable Health Review Final Report in Western Australia. There are a few examples with VBHC, such as the GenesisCare and the High-Value HealthCare Collaborative.[29,30,31]

Tasmania: VBHC is part of the Long-Term plan for Healthcare in Tasmania 2040.[32] The newly formed clinical senate mentions VBHC as a broad policy objective across all health services. In 2021, the Australian Healthcare and Hospitals Association (AHHA) submitted recommendations to the Tasmanian Government on the future of the healthcare system.[33]

Northern Territory: No publicly available initiatives identified for VBHC or VBP. A maximum 30% of tender criteria are based on price (see quote below). Rather, "Value for Territory" criteria are used to support local businesses, needs and supply chains.

> *We procure on a "Value for Territory" basis with a mandatory minimum weighting of 30% applied to Local Content and a maximum 30% of the weighting element on price. Sustainability and supply chain are often included in the criteria."*
>
> **Debra Waters,**
> ***Procurement Project Manager***

> *Being in the Northern Territory, we have some unique challenges in that we are the supplier of last resort, and we treat everything that comes through the doors as it comes. We also have workforce challenges as we are small and far away."*
>
> **William Monaghan,**
> ***Chief Procurement Officer in the Northern Territory***

Australian Capital Territory: No publicly available initiatives were identified for VBHC or VBP in the Australian Capital Territory (ACT).

Summary:

Overall, VBHC is a frequent topic of discussion among the stakeholders interviewed. There is a significant evidence of pilots in the majority of states. However, there is very little holistic movement towards full scale implementation. This is actually consistent with international findings, which suggests Australia could very quickly become a leader with the right focus.

Value-based procurement is less known among the interviewees, but Australia is well placed to on-board VBP. It has mature procurement organisations; the state healthcare systems are aligned and there is a healthy element of competition among the states. Tax and other benefits are available for pilots and for performing clinical trials. The disconnect between acute (public and private) and primary care systems, together with a lack of trust between the different stakeholders, are key barriers to VBHC implementation.

A critical need is strong leadership with a willingness to move VBP forward. In short, a bold leadership initiative is needed to transform the system into a VBHC delivery model. Value-based procurement would be a very promising start to this shift. Drawing from the experience of successful VBHC projects globally (see section 4), collaborative, and inclusive multi-stakeholder dialogue, support from senior leadership and clinical input is vital, and this was articulated through many of the interviews.

Section 5: Implementation by State and Stakeholder – VBHC and VBP in Australia

The desk research and expert interviews suggest Australia has a long way to go before VBHC and VBP are fully embraced. In the transition to VBHC, VBP is a logical way to expand this movement. Organisations such as the AHHA, and the Australian Centre for Value-Based Healthcare (ACVBHC) have done a fantastic job of advocating for the transition to VBHC, and have produced some excellent thought leadership and research on this topic. The medical technology sector aims to support this transition by focusing on VBP. Given the role of procurement for medical technologies reaching patients and clinicians, the medical technology sector can play a significant role in enabling this shift. This section will focus on the implementation of VBP, and the role improved health outcomes and total costs can play for patients and the systems.

Our methodology in examining the maturity is based on Alira Health experience, feedback form expert interviews and extensive desk research. Each Australian state was ranked across a 5-point scale and from each stakeholder perspective. Limitations in the ranking include a relatively small sample size per state per stakeholder, as well potential selection bias in interview candidate perspective. Typically, those advocating for VBHC and VBP are more willing to discuss its merits, and therefore, it is expected there is bias in respondent perceptions. Regardless, the overall trend is the primary metric, and there is a clear desire and direction to move towards VBHC and VBP. Moreover, this direction makes intuitive sense. There is very little case against improving health outcomes and lowering total system costs.

Our ranking scale, per state/territory, per stakeholder was ranked 1 to 5 and based on the following scale:

Table 2. Ranking Scale per State/Territory

Score	Descriptor	Criteria
1	**Low** (No information, no implementation)	No state/territory literature, strategic direction, policy, or VBHC initiatives found. Low awareness and implementation.
2	**Medium/Low** (Some information, no implementation)	Some state/territory literature, strategic direction, policy or VBHC initiatives found online. Stakeholders are interested in implementing VBHC.
3	**Medium** (Some information, some implementation)	VBHC (including VBP) literature, strategic direction, policy and pilots were identified. Pilots were identified but with a limited baseline and measurement of outcomes and costs.
4	**Medium/High** (Robust Information, some implementation)	Value-based language was clearly used in strategic and policy documents, pilots identified, active and with outcomes and/or costs, clear measured and success stories shown, but fragmented examples.
5	**High** (Robust information, robust implementation)	VBHC delivery was full embedded and integrated into the state/territory care model, with alignment from all stakeholders.

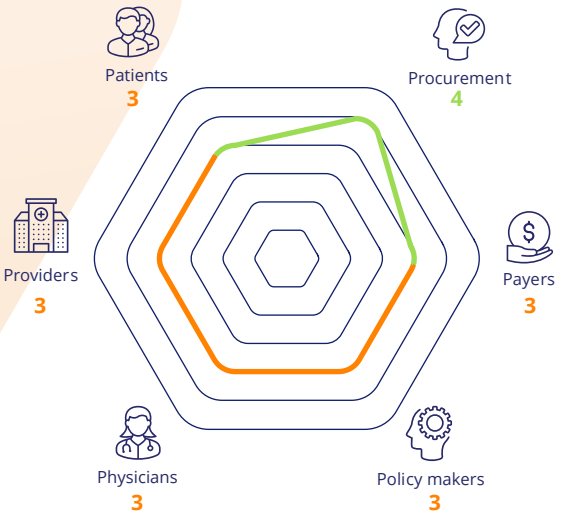
Our research suggests that New South Wales has led the way in setting forward a path to VBP implementation. Victoria and Queensland have also articulated a desire to implement VBHC. The remaining states have some way to go, but there are pockets of excellence. Given the relatively small sample size and potential interview bias, we would strongly welcome further input into refining this scoring system. As a preliminary baseline, our analysis yielded the following results which suggest that Australia has not holistically embraced VBHC and VBP. If Australia were to expand VBHC delivery, patients would experience improved health outcomes, and lower total costs. Value-based procurement would be the medical technology sector's most significant contribution to moving towards a VBHC ecosystem.

Our preliminary baseline rankings by state, are as follows:

EVALUATION SYSTEM: Strong — Weak

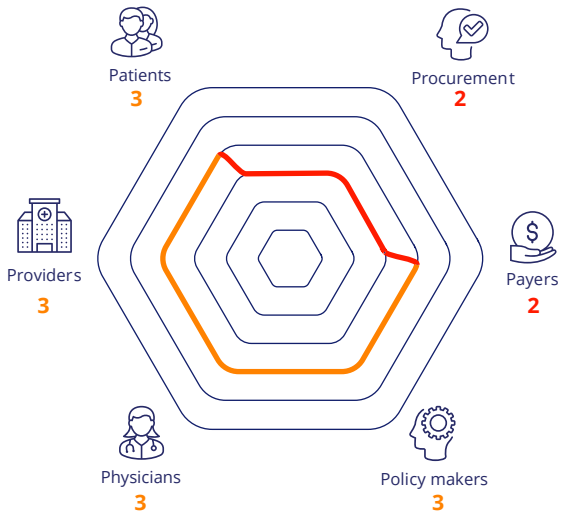
Table 3. Interview & Desk Research Summary by State

NEW SOUTH WALES



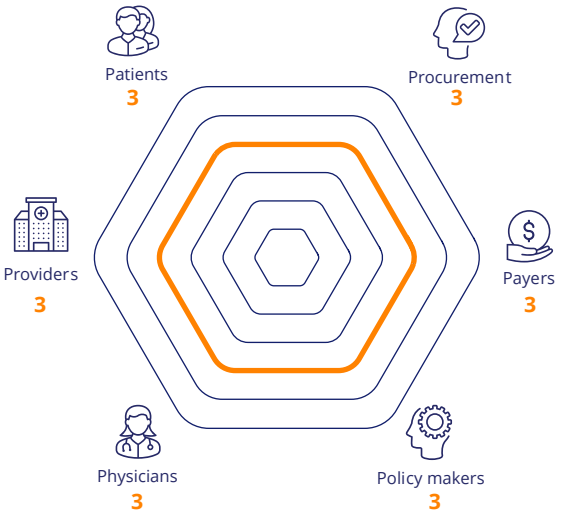
Average Score: 3.17
Australian Rank: 1st
Comment: Strong leadership towards VBHC. Very limited collaboration with the medical technology sector

VICTORIA



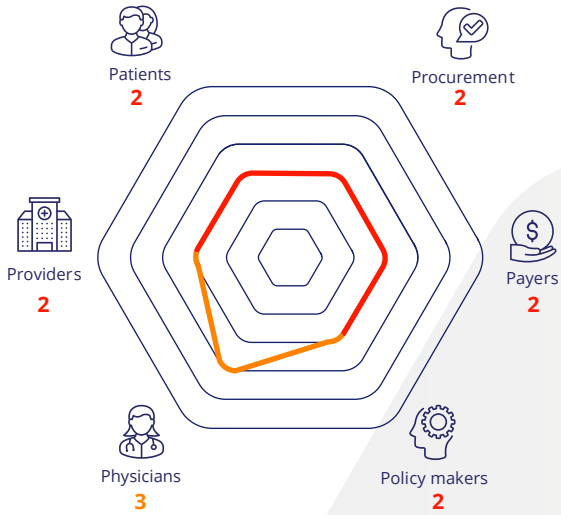
Average Score: 2.67
Australian Rank: 3rd
Comment: Pockets of excellence (TAC, DHSV), but needing strong leadership to implement

QUEENSLAND



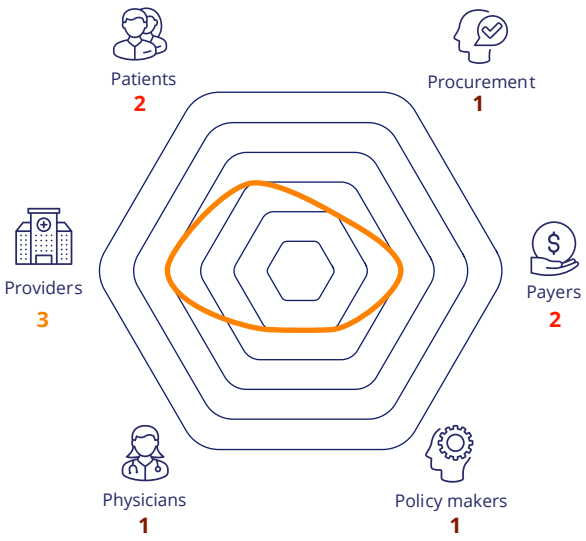
Average Score: 3.00
Australian Rank: 2nd
Comment: Consistently ranked across stakeholders but general knowledge on VBHC and VBP can be improved.

WESTERN AUSTRALIA



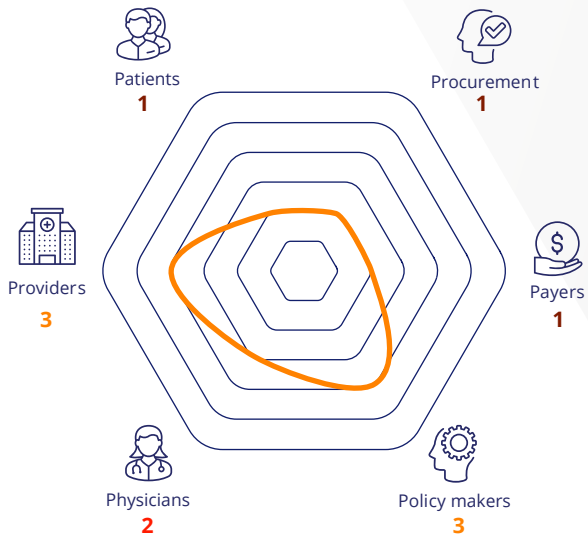
Average Score: 2.17
Australian Rank: 4th
Comment: No overall VBP or VBHC framework identified; however, CIC identified as initiative

SOUTH AUSTRALIA



Average Score: 1.67
Australian Rank: 6th
Comment: Very little awareness or policy for VBHC. There is; however, a statewide PRO initiative identified

TASMANIA



Average Score: 1.83
Australian Rank: 5th
Comment: Strategic direction is to implement VBHC, but more stakeholder knowledge is needed.

Some states have clear value-based objectives but refused comment when it came to understanding how the industry could support the shift. Leaving industry out of the solutions they are to procure represents a major barrier to overcome and raises questions about the viability of such programs. Moreover, with procurement bodies often spending patient and taxpayer funds, one would assume there is a fiduciary obligation to include the most knowledgeable stakeholders about medical technologies in the procurement process: those whose technologies support key care solutions.

Drawing from the experience of successful VBHC projects globally (see section 4), collaborative, and inclusive multi-stakeholder dialogue, support from senior leadership and clinical input are critical to enabling VBHC solutions. Australia has some very strong foundations in place to more fully embed VBP, but a significant amount of work and leadership is needed.

Challenges with VBP Implementation, a Stakeholder Assessment:

Alira Health has conducted numerous value-based healthcare projects globally. The findings from the Australian research and expert interviews align with challenges facing VBHC and VBP globally. These can be grouped into three primary areas:

Technical Knowledge ("WHAT"): The knowledge by therapeutic area collects and aggregates data into baseline costs and outcomes to determine the prospective improvement in those baseline costs and outcomes. This requires having a strong theoretical foundation and technical capability to move from theory to practice.

Talent and Soft Skills ("WHO, WHERE, WHEN and the HOW"): Moving to VBHC/VBP requires a cultural shift in approach across almost all stakeholder groups. Manufacturers need to move to a longer-term approach and move from selling product to selling solutions and outcomes that satisfy a defined unmet need. This is a "cultural" revolution that is needed in healthcare that moves away from perverse financial incentives, silos and hierarchies that stifle physician innovation and new product adoption.

Trust ("WHY"): this is undoubtedly the heart of the issue. There is simply very little trust between stakeholder groups. On countless occasions, VBHC has been coined an enabler for a poorly defined agenda, whether it be a price reduction for payers, price appreciation for the industry, or worse, a rationale to refuse a seat at the table should the "risk" be seen as too high. Trust must be fostered.

On a state-by-state basis, when taken from a multi-stakeholder perspective, against the ability and desire to collaborate across the key challenges, there is a lot of work to be done. This is one of the core reasons a multi-stakeholder Community of Practice is needed in VBP implementation.

When considering the challenges associated with VBHC and VBP implementation, the preliminary rankings by stakeholder, along with recommendations for engagement are as follows:

Table 4. Interview and Desk Research Summary by Stakeholder

STAKEHOLDER	ROLE in VBHC/VBP	Australian Narrative on VBHC and VBP	Recommendation	Average Score	Australian Rank
Physicians: Those delivering the care at the individual patient level.	Key role, as physicians are responsible for delivering the care that drives outcomes, which are the numerator in the VBHC definition.	Most physicians operate on a fee-for-service model, in the private and public system, with no focus on treatment "cost". Physicians are central to care delivery, and successful VBHC and VBP pilots.	Engage across the colleges to build support for clinician-led initiatives. Select key areas such as Orthopaedics and Road Trauma (Victoria) where data is stronger.	**2.50**	**2**
Providers (hospitals): Those providing the place of care either individual or hospital groups.	Key role in care and service organization, funding and procurement of medical technologies. Often the provider collecting outcomes and cost data.	The public and private split have very different incentives and abilities to engage. Care pathways that cross public/private settings seen as a challenge. Public healthcare often too stretched to implement pilot programs.	Potentially start with private systems for pilots, then expand with physicians practicing in the public setting. Public policy will be key to driving a provider-led initiative.	**2.83**	**1**
Patients: The end "consumer" of healthcare.	Central in decision-making (e.g., through PROMS), and shared decision making.	Patients are often not put at the centre of healthcare decision making, instead it is provider driven. VBHC reverses this and ensures care is delivered from a patient perspective.	Engage with key patient groups from key therapeutic areas to build patient input to VBHC and VBP pilot programs.	**2.33**	**5**

STAKEHOLDER	ROLE in VBHC/VBP	Australian Narrative on VBHC and VBP	Recommendation	Average Score	Australian Rank
Procurement: Those purchasing care and services based on an allocated budget.	Responsible for selecting and contracting with the manufacturers or distributors. Work closely together with all stakeholders to finalize the right procurement criteria.	Procurement teams change frequently, they often do not come from healthcare and simply execute on a mandate. Areas of interest to change perspective, but VBP maturity is relatively low.	Engage with key procurement organisations to build a procurement knowledge base through a Community of Practice. Ensure legal requirements and capabilities are understood.	**2.17**	**6**
Payers: Those paying and commissioning healthcare and services.	Define which values to pay for (which technologies to procure) based on the input from the various stakeholders. Move from a price/ volume, and towards an outcome discussion.	Private payers are actively calling for and willing to engage in pilot programs. Public payers need an enabling policy infrastructure to implement VBHC and VBP initiatives. Low ranking due to public payer ability and willingness to engage.	Engage with private payers in potential pilots (similar to provider recommendations). Ensure public payers are included in the dialogue and best practices shared. Identify willing public payers to engage in data collection and pilot programs.	**2.17**	**6**
Policymakers: Those providing the policy frameworks and coverage decisions.	Key role in setting top-down VBHC and VBP frameworks, e.g., regulatory or strategic visions for healthcare provision.	Numerous policy documents identified in numerous states. Strong leader needed to implement the change especially in the public sector. Policy documents alone will not be enough. Strong leadership and risk taking encouraged.	Share best practices in VBHC and VBP that support policy initiatives. Ensure a supportive legislative environment for innovative payment models and data collection.	**2.50**	**2**

When we cross-reference the assessment by state, and with stakeholders, providers often came out with the highest ranking. A potential limitation of the research is the "average" assigned to each stakeholder group and state. In fact, there are pockets of excellence in every state and across every stakeholder. However, there is a significant variation around state and stakeholder willingness and maturity to engage. Therefore, these averages should be taken with some measure of caution, and the general trendline considered. The trendline is key, and suggests VBHC and VBP are generally seen as a necessary shift in Australian healthcare to mitigate the financial and operational challenges.

Levering an Australian example of a VBP initiative shows how this can be done. An embryonic, example of VBP can be found in Queensland. This initiative has significant potential but has been slowed down and halted due to the COVID 19 Pandemic. It is recommended to reactivate and expand this program. It is a multi-stakeholder, clinician led, evidence-based strategy to improve the care delivery in Orthopaedics:

Case Study 6 Australian Example in Queensland in Orthopaedics[36]

Queensland GIRFT Background

In 2018, Queensland Health Strategic Procurement gained an endorsement from the Orthopaedic Directors' Procurement Forum to progress to a clinician-led state-wide procurement model. This was part of the GIRFT program, which was imported from the UK, levering best practices. Originally, only one in three orthopaedic departments would access data captured by the Australian Orthopaedic Association National Joint Replacement Registry (AOANJRR) to monitor outcomes, and average prostheses costs were 1.6 to 1.8 times the operation theatre costs (second-highest direct cost). The average prostheses costs ranged from AUD3.754 to AUD8.269 for hips, and AUD6.028 to AUD11.430 for knees.

Objectives with VBP Model

The objectives of the program were to improve patient outcomes and improve the value for money for the state of Queensland.

Results with the VBP Model

There were some mixed results. Success included improving clinical outcome monitoring and ensuring that 100% of orthopaedic departments had access to their AOANJRR report so they could monitor clinical outcomes. A market share procurement model was established which improved transparency on implant costs and clinical efficacy. Importantly, savings were realised up to 33% on hip, and 25% on knee implant costs via market share commitments. A challenge to this program was highlighted when the COVID-19 pandemic shifted the priority away from orthopaedics towards management of a pandemic. This highlights the resource focus required for successful VBP programs.

The Role of Industry in Australia and VBP

Currently, in Australia, most procurement decisions are determined by price, or at the very least are heavily price dependent. Considering the estimated 5.1% of healthcare spend on medical technologies, dramatically cutting prices in this sector of healthcare will simply not rectify the root issue. Instead, the medical technology sector should be seen as a willing and collaborative partner to support positive change. The medical technology sector is highly innovative, provides significant benefit to economies, and is often significantly undervalued versus its pharmaceutical cousins.

Price-only procurement benefits the procurement teams attempting to manage a very finite budget but it can have significant unintended consequences. If the medical technology sector is the source of economic activity, jobs, clinical trial innovation, design innovation, then all of these are jeopardised if Australia is not seen as an attractive destination. Price-only procurement places significant risk on the manufacturer selling price, revenue, and therefore global investment and innovation. Procurement teams favour price-only procurement because it is easy to implement and very measurable. The cost savings accrue in a very short timeframe, normally within a budget cycle of less than 1 to 3 years. However, this results in an asymmetrical risk against manufacturers and does not incentivise innovation. Prices are lowered, with no opportunity for medical technology solutions to demonstrate improved patient outcomes in a real-world setting. This creates a negative spiral in terms of innovation and has ethical implications whereby technologies demonstrating better health outcomes should be considered over those with very little evidence.

Value-based procurement provides an opportunity to address this. Manufacturers commit to demonstrating improved health outcomes, and more efficient health spending across the care continuum.

Once a technology is assessed and a procurement decision made based on improved outcomes, not solely price, the foundation is set for a full VBHC implementation model. Therefore, the medical technology sector can become part of this paradigm shift, supported by evidence to provide the essential efficiency improvements in the care pathways. Once outcomes across the patient pathway are improved, and total costs more efficiently allocated, healthcare systems begin to benefit, and gains can be fed back into the system. This reverses the negative spiral of a price-only procurement. If healthcare systems are to be rectified, thinking along these lines is needed. The medical technology sector of Australia is committed to being part of this solution.

Other Topics Identified:

As the interviews and desk research were conducted, several other trends emerged that should be considered in the context of VBHC and VBP implementation. Notably, the role VBHC can play in mitigating the variation in health outcomes experienced by Aboriginal and Torres Strait Islander populations, as well as the role of including environmental sustainability in VBP pilots were highlighted. Each of these topics are research reports in their own right, and definitely warrant further analysis and discussion. We would welcome discussing these topics in the context of VBHC implementation.

Summary:

The baseline assessment by state and by stakeholders demonstrates there are pockets of excellence in VBHC and VBP implementation in Australia. However, this is not yet a holistic approach. It is acknowledged that limited input from stakeholders contacted means the average rankings presented above must be taken with some measure of caution; however, the trend suggests VBHC and VBP are the potential solution to the issues Australian healthcare is facing.

Overcoming these challenges requires a new "culture" in healthcare. One that is not defined by dogmatic approaches involving silos and hierarchies, but one that puts the patient at the centre of healthcare decision-making and drives collaboration between all stakeholders. Our systems are broken, and as challenging as these barriers are to overcome, it is possible. The medical technology sector would like the opportunity to earn the trust of all stakeholder groups in enabling this change and redefining the way we deliver healthcare in Australia.

Moreover, VBP is relatively unknown compared with VBHC. As VBP is seen as an enabler of VBHC, more work is needed to support its implementation. The medical technology sector is committed to doing this, and being a collaborative, evidence-based partner in this solution. The next section will focus on some key recommendations to support this evolution.

Section 6: Evidence-Based Recommendations and Call to Action

This White Paper has introduced the challenges healthcare systems globally are facing, and how they relate to the Australian context. Levering a successful international transition to VBHC and VBP, and based on expert feedback, solutions for Australia have been presented. National and international examples have been shared on how VBP can benefit all stakeholders, including patients, physicians, procurement, policymakers, providers, and payers. The expert interviews conducted by Alira Health have found that Australian health stakeholders believe VBHC and VBP should be more holistically implemented across the Commonwealth, and that the Australian healthcare system has the systems and processes required to adopt VBHC and VBP.

However, there are critical elements missing in Australia. The Australian health system has not fully embraced VBHC and VBP. If fully embraced, Australia could also enjoy improved outcomes for patients, more efficient healthcare spending which benefits the overall system.

The overall purpose of this research is to ensure that the medical technology sector is part of a collaborative dialogue to become part of the solution. Therefore, there is the strong recommendation from the MTAA, and organisations globally, that all stakeholder groups have a seat at the table to enable the shift to VBHC. In order to enable this solution, the desk research and expert interviews have yielded some clear levers to enable this change. **These fall under five main categories:**

Recommendation 1: Build a supportive ecosystem for collaborative dialogue through the formation of a VBP Community of Practice.

A VBP Community of Practice is a multi-stakeholder collaboration that shares best practices healthcare pilot programs that emphasise the measurement and improvement of health outcomes and total cost analyses. This would include VBHC and VBP pilot programs.

The mission of the Community of Practice would be to enable a multistakeholder Australian health procurement environment that ensures health-related outcomes are the primary criteria for tendering decisions. The tendering decision-making process should draw input across all key stakeholder groups, including industry, physicians, providers, payers, policy makers, and procurement.

Structurally, this Community of Practice will consist of three main pillars:

1. A VBP "value framework": Building on the strengths of the MedTech Europe value framework, ensuring outcomes and costs are central, we propose emphasising other key domains of value that are relevant to all stakeholder groups. This would include increasing the prevalence of clinician-relevant outcomes as well as increasing the relevance of environmental sustainability.

2. Undertake an extensive stakeholder mapping and prioritisation exercise: ensure a detailed assessment of all stakeholders is undertaken so groups and pilot projects can be effectively prioritised, and areas of focus can be determined.

3. Establish a clear roadmap of implementation: ensure the value framework is taken to the right stakeholders in the right order and build the coalition of the willing along the way. This will respect the "cultural" and technical shift needed to enable VBP. Pilots can be initiated by industry and/or procurement teams and should follow best practices in VBHC and VBP implementation.

In accordance with all procurement and anti-competition law considerations, activities of the Community of Practice will enable knowledge sharing among all stakeholders. This can be done through learning sessions from VBP Pilot Programs, information sessions in the form of online webinars, face-to-face mini-workshops, other knowledge-sharing sessions and conferences, and the creation of tools and materials to guide VBP dialogue. Of note, this will be an arms-length extension of the MTAA Procurement Working Group and will have a supporting and objective Expert Advisory Group to Guide the Community of Practice. Figure 7 represents this visually.

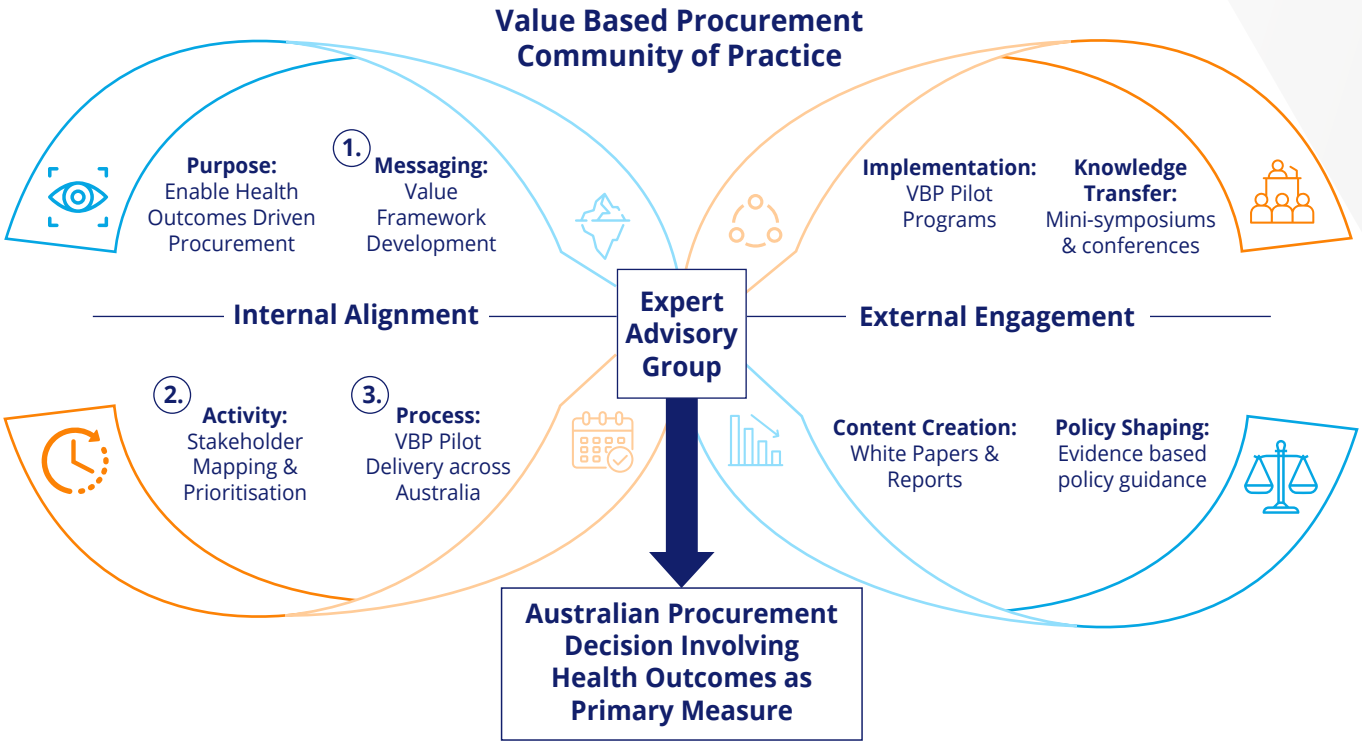


Figure 7. Value-based Procurement Community of Practice

Recommendation 2: Build clinical engagement and leadership.

Physicians are critical to the VBP narrative to ensure clinical and patient outcomes are considered in the procurement decisions. Recommendations should come from expert leaders in the clinical community. As of today, many decisions in Australia are not clinically led. The very nature of medical technologies requires strong support between the industry and the clinical groups. We envision both clinicians and the medical technology sector working together to ensure health-related outcomes are a core criterion of any procurement decision in Australia. We envision this group to start small based on the initial VBP pilots and to grow over time across three primary domains: therapeutic areas, clinical seniority and expertise, and geographic diversity by state/territory.

Recommendation 3: RWE to support procurement decisions.

Australia already has an extremely robust clinical trial environment. Levering this strength, some clear recommendations on RWE will be emphasised. Real-world evidence is data extracted from existing databases or registries that are created to enable evidence-based decision making. Decision-making stakeholders are increasingly getting more demanding in terms of clinical and economical evidence for coverage, funding, access, and reimbursement. Global evidence generation strategies are critical to driving the adoption of innovations and to supporting price points. Real-world evidence data can be used to complement clinical trial data on safety and efficacy, and RWE can be a more effective way of evidence generation compared with costly (randomised) clinical trials.

Real-world evidence is important to VBP initiatives because incremental improvement in costs and outcomes will need to be measured. In the vast majority of examples, either the baseline or the incremental improvement is NOT captured. This complicates the sharing of results of the VBHC/VBP pilots. The use of RWE data is also part of the Australian HTA review, and one of the main commitments under the 2022-27 Strategic Agreement between the Commonwealth and Medicines Australia. The MTAA believes this decision making should include procurement considerations, and therefore, will endeavour to develop a guidance document on the usage of RWE for this purpose.

Recommendation 4: Innovative Funding Models and Risk Sharing.

The funding of healthcare systems needs reform to ensure 21st century application. As highlighted by the Deeble Institute, Australia needs to adapt its funding models.[17] Innovative funding models, risk-sharing agreements and value-based contracting are all potential discussion points with respect to VBHC and VBP. Understanding the basics of risk sharing will support effective dialogue and implementation.

Understanding the nuances and guardrails of risk-sharing agreements will ensure a meaningful dialogue. The MTAA, in collaboration with key thought leaders, will create a guidance document for industry and procurement to engage in innovative funding models, risk-sharing agreements and other collaborative funding mechanisms.

Recommendation 5: Expert Advisory Committee.

The MTAA and the medical technology sector are unable to drive value-based care implementation in isolation, or is any individual stakeholder group. The MTAA will convene an INDEPENDENT (unfunded and transparent) expert advisory board to provide input, guidance, and a multi-stakeholder perspective on the transition to VBP within Australia. One of the outputs of the workstream with the expert advisory committee will be to formulate recommendations to all stakeholders on how to take VBP (E.g. how state health departments could establish VBHC programs, engage industry, create innovation funds, etc..). This expert advisory committee will also be an opportunity to add international experience to the development of VBP in Australia through foreign committee members.

Final Comments

It is through the implementation of this CoP, and the above recommendations, that industry can become a collaborative and engaged partner in the positive changes the Australian healthcare system needs. We welcome all feedback and input to improve and build on the dialogue established in this White Paper.

This White Paper is an open invitation to all partners in health delivery to engage around sustainable and innovative value-based health and the MTAA would welcome your direct contact through its VBP portal:

www.mtaa.org.au

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MTAA Medical Technology Association of Australia

The Medical Technology Association of Australia (MTAA) is the national association representing companies in the medical technology industry. MTAA aims to ensure the benefits of modern, innovative and reliable medical technology are delivered effectively to provide better health outcomes to the Australian community.

www.mtaa.org.au

Cover sheet: Supporting document #2

Guiding Principles for Procurement of Medical Technology

Putting patients at the centre of public health procurement

Public health procurement refers to the process by which state and territory government departments or public hospitals purchase goods or services from companies.

An efficient public procurement environment is critical to ensure all Australians accessing care in our public hospitals have access to world-class medical devices.

Improved public procurement can help to reduce the pressure on health budgets, deliver increased value, and foster the development of high-quality products and innovations in local public hospital markets.

Redesigning the current tender process can unlock substantial shared benefits.

The following guiding principles have been developed to guide all state and territory health procurement agencies towards procurement policy and process reform that puts patient outcomes at the centre of public health procurement.

The MTAA Procurement Forum, made up of public health procurement experts from MTAA member companies, developed the principles.

1. Professionalise procurement to ensure the highest standards of procurement practice

- **Develop consistent best practice processes for tender management across the procurement agency, including:**
    - Pre-tender dialogues and market engagement seeking input from suppliers on tender and contract structure that will best deliver value well in advance of procurement activity,
    - Consistent and easy to complete submission templates,
    - Opportunity to debrief on reasons for award decisions, submission quality, reporting requirements and management of tender process.
- **Maintain fair, transparent and equitable processes** with clear expectations of all parties; and honour agreed-upon terms.
- **Ensure value for money** by reducing administrative costs and enhancing efficiency to ensure suppliers can offer their best price to procurers.
- **Maintain ethical relationships** between companies and health professionals and ensure value for money is achieved through a genuinely competitive process.
- **Ensure tendering document requirements reflect the highly regulated medical device industry -** Eliminate redundant & duplicative terms & conditions and information requests from tender documents to avoid duplicating the role of the TGA.

2. Focus on value and outcomes for patients, healthcare professionals and the health system

- **Ensure patients have the opportunity to access world-class medical devices** through clear and efficient new technology clauses in contracts.

- **Broaden focus from lowest price of products to how medtech procurement can deliver improved outcomes** which matter for patients, improve the experience for clinicians and contribute to the efficiency of the health system.
- **Multistakeholder collaboration and open dialogue** between medical technology suppliers, clinicians, patient groups and health economics experts to define the patient and health system needs that these groups can address.
- **Establish a program of value-based procurement which enables an evidence-based evaluation methodology for how service and product offering can:**
    - improve outcomes for patients,
    - reduce total cost of care, and
    - benefit stakeholders such as health care workers.
- **Commission expertise** to measure the best patient outcomes and the value proposition of a product, service, or solution.
- **Adopt a continuous improvement mindset -** Procurers can learn from initial value-based procurement projects and broaden the application over time.

3. Pursue genuine partnership between industry and government

- **Nurture the relationship between government and medical technology suppliers** to ensure benefits for all parties in the immediate and long term.
- **Focus on a collaborative relationship, not just consultation** – Foster open communication between parties to allow opportunities to raise and work through issues.
- **Procurement & contract staff must be empowered to act** to ensure agency and hospital compliance to contractual obligations and to address issues in an appropriate timeframe.

4. Support an environment for healthcare innovation to thrive

- **Create the environment to enable innovation to flourish** – Innovation of products, services and solutions, which can support new treatments and innovative models of care should be supported and encouraged through tender activity.
- **Recognise the need to ensure the medical devices industry's long-term sustainability** and its contribution to the Australian healthcare system and improving health outcomes for patients.
- **Respecting the confidentiality of contracts and commercial in confidence information** – including when government engages external organisations to manage procurement activity.

Cover sheet: Supporting document #3

PRODUCTIVITY COMMISSION CONSULTATION: PILLAR 4 DELIVERING QUALITY CARE MORE EFFICIENTLY

June 2025

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Table of Contents

About Medical Technology Association of Australia (MTAA)

The **Medical Technology Association of Australia (MTAA)** is the national peak body representing companies in the medical technology (MedTech) industry. MTAA works in partnership with governments across Australia to ensure that contemporary, innovative, and reliable medical technologies are effectively delivered to the Australian community.

MTAA members develop, manufacture, supply, and support a wide range of medical technologies that are essential to modern healthcare. These include:

- **Implantable devices** such as pacemakers and joint replacements
- **Diagnostic equipment** like MRI scanners and X-ray machines
- **Surgical technologies** including robotics and advanced imaging systems
- **Personal health management tools** for chronic conditions such as diabetes
- **Digital health solutions** that integrate data, AI, and connectivity into care delivery

These technologies are used across all healthcare settings—from small rural clinics to large metropolitan hospitals—and play a critical role in detecting, diagnosing, treating, and managing health conditions.

Beyond its clinical impact, the MedTech industry is a significant contributor to the Australian economy. According to the Nous Group's *Value of MedTech* report:

- The industry contributes **$5.4 billion to Australia's GDP**
- It supports over **17,000 direct jobs** and **51,000 total jobs**
- It generates **$1.95 billion in exports**
- It includes over **4,000 manufacturing jobs**
- It has experienced consistent **revenue and employment growth**, with projections indicating continued expansion

MTAA is committed to advocating for policies that improve patient outcomes, enhance system efficiency, and ensure sustainable investment in innovation. Through its advocacy, research, and collaboration with stakeholders, MTAA plays a vital role in shaping the future of healthcare in Australia.

Executive Summary

Australia's healthcare system is under increasing pressure from rising costs, workforce shortages, and growing demand driven by an ageing population and the prevalence of chronic disease. Government spending on care services is projected to rise significantly, making it imperative to find more efficient and sustainable ways to deliver high-quality care. At the same time, the system faces challenges in maintaining productivity, with traditional regulatory and funding models often failing to incentivise innovation or improved outcomes. This was encapsulated in the Productivity Commission's own finding from the *'Advances in measuring healthcare productivity Report, April 2024'* noting 'more timely approval processes for pharmaceutical and other medical technologies would help ensure that the diffusion of new treatments remains a positive contributor to productivity growth.

As the peak body for medical technology manufacturers and suppliers, MTAA supports the Productivity Commission's examination of collaborative commissioning as an approach for the system to deliver quality care more efficiently. MTAA's response will provide a breakdown of how collaborative commissioning could be adopted, based on a form of collaborative commissioning referred to as Value Based Procurement.

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Question 1 What is your experience with collaborative commissioning?	1.1 Explaining the relationship between collaborative commissioning and Value Based Procurement
	1.2 Examples of how VBP works in practice
Question 2: What are the benefits of pursuing greater collaborative commissioning?	2.1 Benefits of pursuing VBP at scale as a form of collaborative commissioning
	2.2 Role of digital health augmenting a VBP collaborative commissioning model
Question 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?	3.1 Barriers to increasing uptake of collaborative commissioning using VBP
	3.2 Solution to encourage uptake of collaborative commissioning using VBP

Question 1: What is your experience with collaborative commissioning?

1.1 THE RELATIONSHIP BETWEEN COLLABORATIVE COMMISSIONING AND VALUE BASED PROCUREMENT

Collaborative commissioning is a model of care planning and delivery where multiple organisations—such as Primary Health Networks (PHNs), Local Hospital Networks (LHNs), and Aboriginal Community Controlled Health Organisations (ACCHOs). These entities can work together to identify population needs, co-design services, procure care, and evaluate outcomes. This procurement models intends to reduce fragmentation, close service gaps, and improve outcomes by aligning efforts across sectors and levels of government.

Similar to the concept of Collaborative Commissioning is the concept of **Value-Based Procurement (VBP)**, which can be considered a form of collaborative commissioning. VBP is based on the principles of Value Based Healthcare which focuses on achieving the best possible health outcomes for patients relative to the total cost of care, considering the entire care pathway. VBP applies this by shifting procurement decisions away from lowest-cost purchasing toward those that deliver the greatest value—measured through improved patient outcomes and system efficiencies.

What distinguishes VBP from traditional collaborative commissioning **is its broader stakeholder engagement to determine value for a range of key health stakeholders**. While collaborative commissioning often involves coordination between government health entities, VBP brings together generally a wider group of actors—clinicians, patients, suppliers, policy makers, and procurement leaders. This inclusive approach ensures that procurement decisions are informed by clinical insight, patient needs, and innovation, not just administrative or budgetary considerations.

1.2 Examples of how VBP in practice

MTAA has identified examples of VBP initiatives in Australia that are done at a local level involving multiple stakeholders involved in delivering care along a patient's journey, demonstrating how it could be embedded as part of a scale up collaborative commissioning approach across both the public and private health systems.

EXAMPLE 1: Care4today Program

In the **Care4today program**, Johnson & Johnson MedTech partnered with St Vincent's Hospital to reduce hospital length of stay (LOS) for joint replacement surgeries. The initiative involved clinicians, hospital administrators, and the supplier working together to redesign care pathways.

1. **Problem Identification**
   The program was initiated to address the backlog of elective surgeries and reduce hospital

length of stay (LOS) for joint replacement procedures, while maintaining or improving patient outcomes.

2. **Stakeholder Collaboration**
   A partnership was formed between Johnson & Johnson MedTech and St Vincent's Hospital. This was a long-term collaboration focused on shared goals.
3. **Program Co-Design of Care Pathway**
   - Pre-operative and post-operative patient education
   - Streamlining at-home care
   - Standardising wound closure products to reduce infection risk
   - Identifying inefficiencies in surgical management with clinical teams
4. **Implementation and Support**
   The supplier worked closely with clinicians to implement the redesigned care pathway, providing tools, training, and support throughout the process.
5. **Outcome Measurement**
   - LOS for total knee replacement reduced from 3.95 to 2.75 days
   - LOS for total hip replacement reduced from 5.41 to 3.44 days
   - Additional benefits included reduced complications and faster recovery
6. **Value Delivered**
   The program generated financial savings through shorter hospital stays and improved patient throughput, demonstrating value beyond the product itself**.**

EXAMPLE 2: Case Study 2: Preventing Surgical Site Infections (SSIs)

1. Problem Identification

Surgical Site Infections (SSIs) account for approximately 15% of all healthcare-associated infections in Australia. In NSW alone, 12% of 10,700 healthcare-associated infections in 2020–21 were SSIs. These infections lead to longer hospital stays, increased patient discomfort, and significant additional healthcare costs—up to $42,102 per case.

2. Stakeholder Collaboration

The initiative involves collaboration between healthcare providers (e.g. hospitals and surgical teams), procurement teams, and medical technology suppliers. This approach also aligns with clinical guidelines from the National Health & Medical Research Council and the World Health Organization, which recommend the use of antimicrobial sutures to reduce SSIs**.**

3. Program Co-Design of Care Pathway

- Identifying high-risk surgical procedures prone to SSIs.
- Selecting wound closure products (e.g. antimicrobial sutures) with proven efficacy in reducing infection rates.
- Incorporating supplier-led training and support to ensure correct product usage.
- Designing procurement contracts that link product use to measurable clinical outcomes.

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4. Implementation and Support

Suppliers would not only provide the products but also support implementation through education, training, and outcome monitoring. Hospitals would be equipped to track infection rates and assess the impact of the intervention.

5. Outcome Measurement

Hospitals would monitor SSI rates before and after implementation. Suppliers would be held accountable for demonstrating reductions in infection rates, with performance benchmarks potentially tied to contract terms.

6. Value Delivered

This VBP model shifts procurement from a cost-based to an outcome-based approach. It delivers value by:

- Improving patient safety and recovery
- Reducing avoidable hospital stays and associated costs
- Enhancing system efficiency
- Potentially saving the health system up to $1.5 billion annually if all hospitals achieved the safety levels of the top 10%

What these examples mean:
Both examples demonstrate how VBP extends collaborative commissioning by engaging a broader group of stakeholders—including industry, clinicians, and patients—in the design, delivery, and evaluation of care. Rather than focusing solely on cost or administrative coordination, VBP fosters partnerships that are outcome-driven, evidence-based, and centred on delivering value across the care continuum.

Question 2: What are the benefits of pursuing greater collaborative commissioning?

2.1 BENEFITS PURSUING COLLABORATIVE COMMISIONING AT SCALE

Pursuing greater collaborative commissioning—particularly through value-based procurement (VBP)—offers significant benefits across the healthcare system by aligning stakeholders around shared goals of improving outcomes and efficiency.

For the Health System

Collaborative commissioning enables smarter resource allocation by focusing on interventions that deliver measurable improvements in patient outcomes. VBP, as a form of collaborative commissioning, shifts procurement from cost-based decisions to those based on long-term value. This reduces waste, avoids duplication, and supports sustainability. For example, programs like Care4today reduced hospital length of stay for joint replacements, freeing up capacity and reducing costs without compromising care quality.

For Patients

Patients benefit directly from services designed around their needs and outcomes. VBP initiatives incentivise suppliers and providers to deliver holistic, outcome-focused care. In the Care4today example, patients experienced shorter hospital stays and improved recovery pathways. Similarly,

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procurement strategies targeting reduced surgical site infections improve safety and reduce complications, enhancing patient experience and health outcomes.

For Clinicians

Clinicians are empowered through collaborative commissioning models that value their input in designing and evaluating care solutions. VBP encourages partnerships between clinicians and suppliers to co-develop care pathways, as seen in the orthopaedic procurement initiative. This fosters clinical ownership, supports evidence-based practice, and reduces administrative burden by aligning procurement with clinical goals.

For Procurement Teams

Procurement professionals' benefit from clearer, outcome-driven frameworks that support strategic purchasing. VBP provides a structured approach to assess value beyond price, incorporating real-world evidence and long-term impact. This enables procurement teams to make informed decisions that align with broader health system objectives, while also fostering innovation and supplier accountability.

What this means:
In summary, collaborative commissioning through VBP creates a more integrated, efficient, and patient-centred care system. It enhances outcomes, reduces inefficiencies, and builds stronger partnerships across the care economy—delivering benefits that extend well beyond traditional procurement models.

2.2 ROLE OF DIGITAL HEALTH IN IMPLEMENTING COLLABORATIVE COMMISSIONING

Building on the benefits of Value-Based Procurement (VBP) as a form of collaborative commissioning, digital health technologies offer a critical enabler for scaling and sustaining these models across the care economy.
Digital health, as it relates to medical technologies, refers to the integration of digital tools and systems into healthcare delivery to enhance clinical decision-making, improve patient outcomes, and increase system efficiency. In the MedTech context, digital health encompasses a wide range of technologies that go beyond traditional medical devices by incorporating data, connectivity, and intelligence into care pathways.

Examples of digital health product categories in the MedTech space include:

- **Remote monitoring devices** (e.g. wearable sensors for cardiac or glucose monitoring)
- **AI-enabled diagnostic tools** (e.g. imaging software that detects abnormalities)
- **Surgical robotics and navigation systems** (e.g. systems that assist in precision surgery)
- **Digital therapeutics** (e.g. software-based interventions for chronic disease management)
- **Connected care platforms** (e.g. telehealth systems and virtual care coordination tools)

These technologies not only support clinical care but also generate valuable data that can inform population health strategies and procurement decisions.

How Digital Health Supports Collaborative Commissioning

Digital health supports collaborative commissioning by providing the infrastructure and intelligence needed to design, implement, and evaluate Value Based Procurement models. Digital tools such as advanced analytics, artificial intelligence (AI), and real-time data platforms can help governments and

health services better understand population needs, identify service gaps, and monitor the impact of interventions.

For example, AI and predictive analytics can be used to forecast patient demand, stratify risk, and identify cohorts that would benefit most from targeted, collaborative interventions. This enables commissioning bodies (eg LHDs, (PHNs), and ACCHOs) to co-design services that are proactive rather than reactive. These insights also support procurement teams in selecting technologies and services that are most likely to deliver measurable improvements in outcomes and efficiency.

Moreover, digital health platforms such as the Single Digital Patient Record (SDPR) and integrated staff tools (e.g. the Digital Front Door app) enhance coordination across providers and streamline workflows. This reduces duplication, improves continuity of care, and ensures that data is available to inform procurement and commissioning decisions.

By embedding digital health into collaborative commissioning, governments can strengthen their capability to deliver value-based health care. This includes using real-world evidence to evaluate supplier performance, adjusting care pathways based on outcomes, and ensuring that procurement decisions are aligned with long-term system goals.

In summary, digital health is not just a support tool—it is a foundational enabler of collaborative commissioning through Value Based Procurement. It empowers stakeholders with the data and systems needed to deliver integrated, efficient, and patient-centred care.

Question 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?

In your response to this question, you might want to provide specific suggestions about changes to governance or funding that could lead to greater collaboration between PHNs, LHNs and ACCHOs, or feedback on any additional considerations for ACCHOs collaborating with LHNs and PHNs.

3.1 BARRIERS TO COLLABORATIVE COMMISSIONING

Collaborative commissioning faces several barriers that limit its uptake and effectiveness across the care economy. From MTAA's perspective, key challenges include:

Fragmented Governance and Procurement Silos

One of the primary barriers is the lack of coordination between different levels of government and across departments. Procurement processes are often siloed, with limited mechanisms for joint planning or shared accountability. This fragmentation makes it difficult to align funding, service design, and outcome measurement across sectors such as health, disability, and aged care.

Limited Stakeholder Engagement

Collaborative commissioning is often confined to government entities, excluding key stakeholders such as industry partners. This narrow approach limits innovation and fails to leverage the expertise of those directly involved in care delivery and technology development.

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Lack of Awareness and Uptake at the Local Level
Even where value-based procurement initiatives exist, such as the NSW statewide orthopaedic contract, there is limited awareness and adoption among Local Health Districts (LHDs). This reflects a broader challenge in translating central policy into local practice.

Inadequate Use of Data and Outcomes Measurement
Effective collaborative commissioning requires robust data to identify needs, track outcomes, and evaluate impact. However, many systems lack the digital infrastructure and analytical capability to support this. Without clear metrics, it is difficult to hold partners accountable or demonstrate value

3.2. SOLUTIONS TO STRENGTHEN COLLABORATIVE COMMISSIONING

- **Encourage the Commission to adopt MTAA Procurement Principles**, which provide a practical framework to enhance collaborative commissioning models. These principles include
  - **Professionalise procurement** to ensure high standards and consistency across jurisdictions.
  - **Focus on value and outcomes** for patients, clinicians, and the health system, rather than lowest-cost purchasing.
  - **Foster genuine partnerships** between government and industry, enabling co-designed solutions.
  - **Support innovation**, ensuring that procurement processes do not act as a barrier to the adoption of new technologies.
- **Embed Value-Based Healthcare into Procurement activity**: Integrating VBHC into broader procurement strategies ensures that purchasing decisions support long-term health outcomes, not just short-term cost savings.
- **Invest in Digital Health Infrastructure**: Enhancing AI and data analytics capabilities enables predictive modelling, risk stratification, and real-time outcome tracking—critical tools for planning and evaluating collaborative initiatives.
- **Promote Local Engagement and Capacity Building**: Targeted support for LHDs and PHNs to adopt collaborative models, including training and incentives, can bridge the gap between policy and practice.

NSW Special Commission of Inquiry into HealthCare Funding - Recommendations on Procurement
The NSW Special Commission of Inquiry into Healthcare Funding (2025) made key recommendations to embed value-based healthcare principles into procurement processes across NSW Health. These recommendations were informed by stakeholder submissions, including the Medical Technology Association of Australia (MTAA), and supported by evidence from the MTAA commissioned Alira Health report on Value-Based Procurement in Australia. The Inquiry recognised the need for systematic approaches to defining, evaluating, and embedding "value" in procurement—beyond cost—to include patient outcomes, clinical input, and broader system benefits. It also called for formalised roles for agencies such as the ACI and CEC in procurement processes. These findings underscore the importance of aligning procurement frameworks with value-based healthcare objectives to drive better health outcomes and system efficiency. MTAA encourages the Productivity Commission to examine these in parallel to MTAA's submission.

By addressing these barriers through Value Based Procurement using the proposed solutions, collaborative commissioning can become a more effective, inclusive, and outcomes-driven approach to delivering quality care.

Conclusion

MTAA recognises the growing pressures on the health system, including rising demand, workforce constraints, and fiscal sustainability challenges. Collaborative commissioning, through leveraging value-based procurement, offers a practical pathway to address these challenges. It enables health organisations to work together across sectors and jurisdictions, aligning services with population needs and ensuring that investments deliver measurable improvements in outcomes.

MTAA strongly supports the Commission's focus on embedding collaborative commissioning across the care economy. We believe this approach must be underpinned by:

- Inclusive, multi-stakeholder engagement—including clinicians, patients, suppliers, and policymakers
- A shift from volume-based to value-based funding and procurement models
- Investment in digital health and data analytics to support planning, monitoring, and evaluation
- Streamlined regulatory and procurement processes that enable innovation and responsiveness

MTAA urges the Commission to recommend the development of a national framework that supports collaborative commissioning and incentivises Value Based Procurement models. This should include mechanisms to scale successful initiatives, share best practice, and ensure that procurement and commissioning decisions are informed by real-world evidence and long-term value.

MTAA welcomes the opportunity to continue working with government and sector partners to advance these reforms. By embracing collaborative commissioning through Value Based Procurement, Australia can build a more sustainable, equitable, and high-performing care economy that delivers better outcomes for all.

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Cover sheet: Supporting document #4

Chapter 20:

Procurement

Volume 1

Contents

Introduction

20.1. Procurement within any organisation the size of NSW Health is inevitably complex.

20.2. Those complexities are heightened in the context of government procurement and the expenditure of public funds. In this respect, NSW Health's procurement activities are subject to a range of legislative requirements, NSW Government level policies and oversight by the central NSW Procurement Board, and are governed by a wide range of policies, guidelines and procedures.

20.3. As might be expected, those activities are extensive, and are spread across the entire system, from Ministry of Health to local facility level.[763] In the 2023–24 financial year, NSW Health spent approximately $8.86 billion on goods and services, representing approximately 28 per cent of NSW Health's total expenditure.[764]

20.4. Although (as NSW Health recognised) there are improvements that can be made, there are many aspects of its approach to procurement that currently work well and provide good support for the wider system. Some of those strengths were demonstrated during the pandemic, even if those events themselves highlighted areas for improvement.[765]

20.5. In that context, the key themes that emerged in the evidence did not relate to the system's capacity to respond to events of urgency and scale, nor to the general day to day processes of procurement, although no doubt those areas will benefit from a continued process of improvement and enhancement. Rather, the key issues arise at a higher level: for example, how the system regards, evaluates and puts into practice the concepts of value, and how it measures and monitors procurement outcomes, including as against those concepts.

20.6. As is explored in this chapter, "value" is a prominent theme in NSW Government and NSW Health procurement strategies and frameworks.

20.7. It is uncontroversial that delivering the highest value healthcare for the money expended should be a priority in any procurement process; a concept that is sometimes described as "value based healthcare". However, as NSW Health rightly submitted, in the overall context of the NSW Government Procurement Framework, the concept of "value for money" is broader than value based healthcare. Accordingly, it must be remembered in any consideration of NSW Health's approach to procurement that, in the wider

[763] This section of the Report addresses NSW Health's procurement of goods and services, as opposed to workforce (such as the engagement of locums and agency nurses). The latter is considered elsewhere in the Report.

[764] Exhibit N.3.27, NSW Health Annual Report 2023-24 (October 2024) p 152 [SCI.0011.0717.0001 at 0160].

[765] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [28], [58]-[59] [MOH.0001.0434.0001 at 0006, 0020]; Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [113] [MOH.9999.0009.0001 at 0031].

government context, a range of criteria beyond monetary value must be incorporated into procurement plans and tender evaluation processes.[766]

20.8. Ultimately, as NSW Health accepted, there are several ways in which NSW Health's procurement processes can be improved and strengthened to better meet those objectives, including through actions to:[767]

a. improve the incorporation of value based criteria into procurement plans and tender evaluation processes;

b. introduce a common set of evaluation criteria specifically related to clinical outcomes into NSW Health procedures as a starting point for personnel to draw upon; and

c. reinforce value based healthcare principles in procurement by further training offered by Ministry's Strategic Procurement Branch.

Roles and responsibilities in relation to procurement activities

20.9. In the paragraphs that follow, a general summary of the roles and responsibilities of various agencies (within NSW Health and across government more broadly) relating to NSW Health's procurement activities are set out.

NSW Procurement Board

20.10. The procurement of goods and services by or on behalf of a NSW Government agency (which includes NSW Health)[768] is subject to Part 11 of the *Public Works and Procurement Act 1912* (NSW).[769]

20.11. The *Public Works and Procurement Act* established the NSW Procurement Board,[770] whose functions include the development and implementation of policies for, and the oversight of, the procurement of goods and services by and for government agencies.[771]

20.12. Government agencies are obliged to comply with any directions or policies issued by the Board, the terms of any accreditation granted to them, and "the principles of probity and fairness".[772] A government agency "is also to ensure it obtains value for

[766] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [12.9] [SCI.0011.0814.0001 at 0116-0117]; See, for example, Exhibit B.23.16, NSW Government, *Procurement Policy Framework* (April 2022) [MOH.0001.0132.0001]; Exhibit B.23.18, NSW Government, *Small and Medium Enterprise and Regional Procurement Policy* [MOH.0001.0417.0001].

[767] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [12.10] [SCI.0011.0814.0001 at 0117].

[768] Public Works and Procurement Act 1912 (NSW) s 162.

[769] Public Works and Procurement Act 1912 (NSW) s 163.

[770] Public Works and Procurement Act 1912 (NSW) s 164.

[771] Public Works and Procurement Act 1912 (NSW) s 172.

[772] Which are not defined: *Public Works and Procurement Act 1912* (NSW) s 176(1).

money in the exercise of its functions in relation to the procurement of goods and services".[773]

20.13. The NSW Procurement Board established accreditation programs pursuant to the *Public Works and Procurement Act.*[774] Under the goods and services accreditation program, the Board accredits an agency to conduct procurement for itself or other government agencies. It may also authorise a government agency to carry out specified procurement of goods and services without accreditation. The goods and services accreditation program has two levels of accreditation. Level 1 accredited agencies may independently conduct procurement activities up to a maximum contract value based on whether the risk profile of the procurement is low, medium, or high risk. Level 2 accredited agencies may independently conduct procurement activities in line with approved budgets, financial delegations and procurement delegations.[775] The Health Administration Corporation holds a "Level 2" accreditation,[776] which means it is authorised to procure goods and services of any value without reference to the Board.[777]

20.14. The NSW Procurement Board has also issued a range of mandatory directions and policies in accordance with the *Public Works and Procurement Act,*[778] as well as a range of non-binding guidelines, which are summarised in the NSW Government *Procurement Policy Framework*.[779] They relate to such matters as:

a. non-discrimination, and general use of open approaches to market for procurement;[780]

b. prioritising procurement from small and medium enterprises and regional businesses,[781] including specific targets relating to ICT and digital procurement;[782]

[773] Public Works and Procurement Act 1912 (NSW) s 176(3).

[774] *Public Works and Procurement Act 1912* (NSW) s 174; Exhibit B.23.16, NSW Government, *Procurement Policy Framework* (April 2022) pp 6, 43-45, 144 [MOH.0001.0132.0001 at 0006, 0043-0045, 0144]. Those directions are in addition to various legislative obligations that apply directly to procurement activities, such as those that arise under the *Modern Slavery Act 2018* (NSW).

[775] Exhibit B.23.16, NSW Government, *Procurement Policy Framework* (April 2022) pp 142, 144 [MOH.0001.0132.0001 at 0142, 0144]; Exhibit B.5, Statement of Michael Gendy (31 January 2024) [35] [MOH.0001.0434.0001 at 0008].

[776] Exhibit B.23.25, NSW Health, *Corporate Governance & Accountability Compendium* (September 2023) pp 12.05-12.06 [MOH.0001.0297.0001 at 0125-0126]; Exhibit B.23.15, Audit Office of NSW, *Ensuring Contract Management Capability in Government – HealthShare NSW* (31 October 2019) p 1 [MOH.0001.0013.0001 at 0005]; Exhibit B.5, Statement of Michael Gendy (31 January 2024) [17]-[19] [MOH.0001.0434.0001 at 0004].

[777] Exhibit B.23.16, NSW Government, *Procurement Policy Framework* (April 2022) p 144 [MOH.0001.0132.0001 at 0144].

[778] Contraventions of certain Board directions or policies are enforceable: *Public Works and Procurement Act 1912* (NSW) ss 176D-176F.

[779] Exhibit B.23.16, NSW Government, *Procurement Policy Framework* (April 2022) [MOH.0001.0132.0001].

[780] Exhibit B.23.95, NSW Procurement Board, *Procurement (Enforceable Procurement Provisions) Direction* 2019 [MOH.0001.0121.0001].

[781] Exhibit B.23.18, NSW Government, *Small and Medium Enterprise and Regional Procurement Policy* (July 2021) [MOH.0001.0417.0001].

[782] Exhibit B.23.19, NSW Government, *ICT/Digital SME procurement commitments* (19 December 2022) [MOH.0001.0334.0001].

c. payment terms for small businesses;[783]

d. prioritising procurement from Aboriginal businesses;[784]

e. environmental sustainability;[785]

f. dealing with unsolicited proposals;[786] and

g. a mandated contracting framework for ICT procurement.[787]

20.15. NSW Health's procurement activities are also subject to several other legislative obligations, such as those that arise under the *Modern Slavery Act 2018* (NSW).

Health Administration Corporation

20.16. Although the Health Administration Corporation holds the accreditation to undertake procurement for NSW Health, that function is largely exercised through HealthShare, as well as eHealth in relation to ICT procurements, for procurements that have a value of up to $30 million, and/or recurrent yearly payments in aggregate up to $30 million in the case of eHealth.[788] Procurement of goods or services exceeding those thresholds must be approved by the Chief Procurement Officer.[789]

HealthShare

20.17. The predecessor of HealthShare – Health Support Services – was established in 2007 to provide shared services for NSW Health entities, including linen, food, payroll, warehousing, procurement and recruitment services, as well as some ICT services.[790]

20.18. In 2012, Health Support Services was renamed HealthShare NSW, and created as an "administrative unit" of a "division" of the Health Administration Corporation. [791] HealthShare became the vehicle through which the Health Secretary provided those

[783] Exhibit B.23.20, NSW Government, *Small Business Shorter Payment Terms Policy* (July 2021) [MOH.0001.0416.0001].

[784] Exhibit B.23.21, NSW Government, *Aboriginal Procurement Policy* (January 2021) [MOH.0001.0277.0001].

[785] Exhibit B.23.22, NSW Government, *NSW Government Resource Efficiency Policy* (2019) [MOH.0001.0324.0001].

[786] Exhibit B.23.96, NSW Department of Premier and Cabinet, *Unsolicited Proposals* (C-2017-05) (22 December 2017) [MOH.0001.0428.0001]; Exhibit B.23.97, NSW Government, *Unsolicited Proposals Guide for Submission and Assessment* (May 2022) [MOH.0001.0427.0001].

[787] Exhibit B.23.99, NSW Procurement Board, *Mandated use of ICT Purchasing Framework* (PBD-2021-02) (1 July 2021) [MOH.0001.0341.0001].

[788] Exhibit B.23.25, NSW Health, *Corporate Governance & Accountability Compendium* (September 2023) pp 12.05-12.06 [MOH.0001.0297.0001 at 0215-0216]; Exhibit D.1.57, NSW Health, *eHealth NSW Delegations Manual* – Version: 3.0 (May 2019) pp 15, 16, 19 [MOH.9999.0819.0001 at 0015, 0016, 0019].

[789] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [75a] [MOH.0001.0434.0001 at 0026].

[790] See, for example, Exhibit B.23.36, NSW Director-General, *Future Arrangements for Governance of NSW Health* (2011) p 27 [MOH.0001.0309.0001 at 0029].

[791] Exhibit B.23.37, *Delegation of functions of the HealthShare NSW Board* (29 November 2012) recital B [MOH.0001.0308.0001 at 0001].

shared services under s 126B of the *Health Services Act*, with its governance overseen by the HealthShare Board.[792] That structure remains in place today.

20.19. Since 10 November 2008, public health organisations have been directed by the Minister to acquire all procurement, contract management and contract negotiation services from HealthShare (and its predecessor, Health Support Services).[793] That direction is binding on public health organisations other than AHOs, which can elect whether to acquire those services from HealthShare.[794]

20.20. HealthShare is funded primarily on this "cost recovery" model through intrahealth service charges, together with a recurrent subsidy.[795]

20.21. Relevantly, public health entities[796] pay a "recovery charge" to HealthShare for its services, unless otherwise approved by the Health Secretary.[797] Procurement contract and tendering services are charged at a fixed price,[798] while a volume based charge is applied to the acquisition of goods through the centralised "Onelink" warehouse.[799] Those volume based charges include components for the item itself, warehousing operations, and freight cost.[800]

20.22. HealthShare's procurement related activities fall into the following general categories:[801]

a. Leading the process for establishing and renewing of whole of NSW Health and whole of NSW Government (health related) arrangements for purchasing goods and services.[802] HealthShare's responsibilities include developing a procurement plan; preparing tender documentation (assuming, as is usual, that the procurement is to be by way of an approach to market); preparing evaluation criteria and an evaluation plan; conducting the tender and evaluation process; and preparing and finalising the contract, in accordance with the NSW Health Procurement Policy and Procedures and other relevant policies and

[792] Health Services Act 1997 (NSW) s 126C.

[793] Exhibit B.23.39, Order pursuant to s 126G of the *Health Services Act 1997* (10 November 2008) [MOH.0001.0404.0001]; See also, Exhibit B.23.35, NSW Health, *Accounts and Audit Determination for Public Health Entities in NSW* (9 March 2020) p 26 cl 4.1(a)(i)(2) [MOH.0001.0278.0001 at 0027].

[794] *Health Services Act 1997* (NSW) ss 126G, 126H (2).

[795] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [25] [MOH.9999.0009.0001 at 0009].

[796] Exhibit D.95, NSW Ministry of Health, A*ccounts and Audit Determination for Public Health Entities in NSW* (9 March 2020) p 30 [SCI.0008.0112.0001 at 0031]. A public health entity means a public health organisation and the divisions of the Health Administration Corporation.

[797] Exhibit D.95, NSW Ministry of Health, A*ccounts and Audit Determination for Public Health Entities in NSW* (9 March 2020) p 27 cl 4.1(c) [SCI.0008.0112.0001 at 0028]. The recovery charge will be paid by the Ministry of Health on behalf of the public health organisation.

[798] See, for example, Exhibit B.1, Statement of Margot Mains (29 January 2024) [36] [MOH.0001.0260.0001 at 0013-0014].

[799] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [28] [MOH.9999.0009.0001 at 0009].

[800] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [28(b)] [MOH.9999.0009.0001 at 0009].

[801] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [31] [MOH.9999.0009.0001 at 0011].

[802] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [42] [MOH.9999.0009.0001 at 0014].

procedures.[803] The result of those processes is generally a "Standing Offer Arrangement" between the relevant supplier and the Health Administration Corporation, which sets out the terms and conditions on which contracts may be formed between the supplier and individual NSW Health entities.[804]

b. Conducting procurements referred to it by other NSW Health entities that are outside their authority.[805] That process is a similar process to establishing a whole of NSW Government or whole of NSW Health contract, but the result is a single contract between the supplier and the relevant NSW Health entity, rather than the Health Administration Corporation.[806]

c. Contract management and administration of whole of NSW Health and whole of NSW Government (health related) contracts.[807]

d. Procuring, warehousing, and delivering of a wide range of medical and surgical consumables used in NSW Health facilities through the "Onelink" warehouse – a centralised warehouse from which HealthShare then distributes consumables.[808] In doing so, HealthShare procures three million different medical and surgical consumables worth about $200 million annually and delivers these across 400 sites every day.[809] HealthShare also maintains a product catalogue and various supply chain information systems for use by NSW Health entities.[810]

e. Providing assistance and advice to other NSW Health staff, particularly at the local level, regarding procurement matters.[811]

f. The development of procurement strategy and reform, including category strategies as described above.[812]

eHealth

20.23. eHealth was established on 1 July 2014 as another "unit" within the Health Administration Corporation.[813] It was established to centralise ICT services for NSW Health, which at that time were spread between what were the then Area Health Services and Health Support Services, as well as the Ministry of Health.[814] Its current

[803] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [61]-[67] [MOH.9999.0009.0001 at 0017-0021].

[804] See, for example, Exhibit B.23.40, Template Standing Offer Agreement (13 December 2022) [MOH.0001.0367.0001].

[805] Generally, procurement valued in excess of $250,000 and outside a whole of NSW Government or whole of NSW Health contract: Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [31(c)], [61]-[67] [MOH.9999.0009.0001 at 0011, 0017-0021].

[806] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [31(c)] [MOH.9999.0009.0001 at 0011].

[807] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [49]-[56] [MOH.9999.0009.0001 at 0015-0016].

[808] Transcript of the Commission, 23 February 2024, T895.36-896.14, T921.33-923.6 (Rechbauer).

[809] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [34] [MOH.9999.0009.0001 at 0012].

[810] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [31f] [MOH.9999.0009.0001 at 0011].

[811] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [35]-[36] [MOH.9999.0009.0001 at 0012].

[812] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [86]-[102] [MOH.9999.0009.0001 at 0024-0029].

[813] Exhibit B.23.124, eHealth Determination of Functions (2 June 2023) recital A [MOH.0001.0312.0001 at 0001].

[814] Exhibit B.23.36, NSW Director-General, *Future Arrangements for Governance of NSW Health* (2011) p 24 [MOH.0001.0001.0309.0001 at 0026].

functions include planning, strategy development, project development, support and maintenance of ICT for NSW Health, as well as the provision of network and storage facilities, and ICT hardware and software.[815]

20.24. Similar to HealthShare, NSW Health entities (other than AHOs) are obliged to acquire ICT goods and services that are offered by eHealth.[816] Those goods and services extend to most ICT infrastructure (including NSW Government data centres and the cloud), corporate/business systems (such as incident management, payroll, recruitment and finance systems), cyber security services, communications platforms (including email and video conferencing), clinical systems (such as electronic patient medical records, imaging, pharmacy and ambulance systems), and virtual care systems.[817]

20.25. eHealth's ordinary operations are funded in a similar way to HealthShare: partly through recurrent funding from the Ministry of Health, but primarily through service charges levied on NSW Health entities for using its services, either on a fixed or consumption basis.[818] Statewide programs and projects may receive separate capital funding.[819]

20.26. In performing its functions, eHealth:

a. negotiates and manages whole of NSW Health contracts for ICT goods and services, by establishing "Master" or "Head" agreements with suppliers pursuant to which NSW Health entities may then contract;[820]

b. negotiates contracts on behalf of NSW Health entities for ICT goods and services outside whole of NSW Health and whole of NSW Government contracts and above their financial authority, which (in accordance with the NSW Health Procurement Policy) is $150,000;[821] and

c. is involved in the development of strategies and reforms relating to ICT in NSW Health.[822]

20.27. It is also required to approve any laptop or desktop purchases within NSW Health of any value, for standardisation reasons.[823]

[815] Exhibit B.23.124, eHealth Determination of Functions (2 June 2023) [2] [MOH.0001.0312.0001 at 0001].

[816] Exhibit B.23.39, Order pursuant to s 126G of the *Health Services Act 1997* (10 November 2008) cl 3 [MOH.0001.0404.0001]; Exhibit B.23.35, NSW Ministry of Health, *Accounts and Audit Determination for Public Health Entities in NSW* (9 March 2020) p 26 cl 4.1(a)(iii) [MOH.0001.0278.0001 at 0027].

[817] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [10], [53] [MOH.0001.0433.0001 at 0002 and 0026-0027].

[818] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [15]-[17] [MOH.0001.0433.0001 at 0003].

[819] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [17(a)], [18] [MOH.0001.0433.0001 at 0003, 0004].

[820] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [46]-[48] [MOH.0001.0433.0001 at 0024].

[821] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [42(b)] [MOH.0001.0433.0001 at 0022].

[822] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [26]-[32] [MOH.0001.0433.0001 at 0005-0020].

[823] Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [43] [MOH.0001.0433.0001 at 0022-0023].

Ministry of Health

20.28. Aside from procurement activities it may undertake for its own purposes, the Ministry of Health has what has been described as a "strategic" role in relation to procurement.[824] That role broadly reflects the Ministry of Health's function as "system manager".[825]

20.29. The Ministry of Health is responsible for developing and overseeing the general framework of policies, procedures and guidelines applying to procurement across NSW Health. The most notable of these are the *NSW Health (Goods and Services) Procurement Policy*[826] and *NSW Health Procurement Procedures (Goods and Services)*.[827] A wide range of separate, specific policies also bear on the procurement function.[828] Public health organisations are required to comply with the NSW Health Procurement Policy and Procedures as a condition of the financial subsidies they receive.[829]

20.30. The Ministry of Health's Strategic Procurement Branch has a lead role in the implementation of the procurement related elements of the *Future Health Plan*.[830] It also has responsibility for overseeing the current "Procurement Reform Program".[831]

20.31. The Chief Procurement Officer has a range of responsibilities that are particularly focussed on procurement activities that are outside the ordinary course and, as noted above, include approving procurement at or over $30 million in value and procurement plans and evaluation plans, and establishing whole of NSW Health contracts, as well as granting exemptions to existing procurement requirements.[832]

20.32. The Ministry of Health also oversees compliance with procurement requirements and functions by other entities within the system.[833] The main way in which this occurs is

[824] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [22] [MOH.0001.0434.0001 at 0004-0005].

[825] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [9]-[10], [20] [MOH.0001.0434.0001 at 0002-0003, 0004].

[826] Exhibit B.23.13, NSW Health Procurement (Goods and Services) Policy (PD2023_028) (4 October 2023) [MOH.0001.0037.0001].

[827] Exhibit B.23.14, NSW Health Procurement Procedures (Goods and Services) (June 2022) [MOH.0001.0366.0001].

[828] Some examples include: Exhibit B.23.28, NSW Health, *Disclosure of Contract Information* (PD2018_021) (26 June 2018) [MOH.0001.0148.0001]; Exhibit B.23.29, NSW Health, *Conflicts of Interest and Gifts and Benefits* (PD2015_045) (27 October 2015) [MOH.0001.0145.0001]; Exhibit B.23.30, NSW Health Code of Conduct (PD2015_049) (16 December 2015) [MOH.0001.0359.0001]; Exhibit B.23.31, NSW Health, *Corrupt Conduct - Reporting to the Independent Commission Against Corruption (ICAC)* (PD2016_029) (5 July 2016) [MOH.0001.0298.0001]; Exhibit B.23.32, NSW Health, *Procurement Cards within NSW Health* (PD2022_038) (2 September 2022) [MOH.0001.0149.0001]; Exhibit B.23.43, NSW Health, *Asset Management* (PD2022_044) (19 September 2022) [MOH.0001.0150.0001]; Exhibit B.23.46, NSW Health, *Uniforms Policy* (PD2019_012) (22 March 2019) [MOH.0001.0369.0001]; NSW Health, *Early Response to High Consequence Infectious Disease* (PD2023_008), referred to in Exhibit B.5, Statement of Michael Gendy (31 January 2024) [53(e)] [MOH.0001.0434.0001 at 0018].

[829] See, for example, Exhibit B.23.100, NSW Ministry of Health Financial Requirements and Conditions of Subsidy (Government Grants) for the year ending 30 June 2023 (21 June 2022) p 24 cl 3.5 [MOH.0001.0318.0001 at 0025].

[830] Exhibit B.23.23, NSW Health, *Future Health: Guiding the next decade of healthcare in NSW 2022-2023* (May 2022) [MOH.0001.0320.0001]; Exhibit B.5, Statement of Michael Gendy (31 January 2024) [29] [MOH.0001.0434.0001 at 0006].

[831] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [30]-[31] [MOH.0001.0434.0001 at 0006-0007].

[832] Exhibit B.23.13, NSW Health Procurement (Goods and Services) Policy (PD2023_028) (4 October 2023) pp ii, 5,6,14,15, 30 [MOH.0001.0037.0001 at 0003, 0009, 0010, 0018, 0019, 0034]; Exhibit B.5, Statement of Michael Gendy (31 January 2024) [75b] [MOH.0001.0434.0001 at 0026].

[833] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [22f], [35] [MOH.0001.0434.0001 at 0005, 0008].

through the setting and monitoring of KPIs relating to procurement in the service agreements between the Health Secretary and LHDs, SHNs and AHOs, and Statements of Service with HealthShare, eHealth, NSW Health Pathology and Health Infrastructure.[834] Those KPIs are focussed on cost savings (for example, "annual procurement savings target achieved"), standardisation (for example, "reducing free text orders catalogue compliance", "reducing off-contract spend" and "use of Whole of Health contracts"), and environmental sustainability (for example, reducing the use of certain chemicals and diverting waste from landfill).[835]

Pillar organisations

20.33. The ACI and the CEC also play a role, albeit an *ad hoc* one, in procurement processes.

20.34. There is likely to be significant system benefits if those agencies were to have a systematic role in the procurement processes. By the very nature of their function, they have valuable system and clinical knowledge that could be brought to bear in the procurement processes in a way that will promote value based procurement principles. The current *ad hoc* role they perform should be formalised so that those undertaking procurement have clear guidance as to when the input of those agencies should be sought.

Agency for Clinical Innovation

20.35. The ACI and the Office of Health and Medical Research (OHMR) have a significant role to play in identifying, assessing, developing and implementing clinical and technical innovations within NSW Health.[836]

20.36. At present, no clear role for the ACI in NSW Health's procurement processes is identified, outside of implementing clinical innovations sponsored by it.

20.37. In this respect:

a. its role in tender evaluation processes is largely *ad hoc* and it generally depends on whether the members of the technical evaluation committee for the tender elect to involve it;[837]

b. as Adjunct Professor Levesque explained,[838] the ACI does not undertake monitoring of the effects of clinical products procured via Statewide contracts in a

[834] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [51]-[55] [MOH.0001.0434.0001.0017-0019].

[835] See, for example, Exhibit B.23.181, Southern NSW Local Health District Service Agreement 2023-24 (26 October 2023) p 27 [MOH.0001.0456.0001 at 0028].

[836] See, for example, Exhibit B.3, Statement of Adjunct Professor Jean-Frédéric Levesque (30 January 2024) [66]-[85]. [MOH.0001.0435.0001 at 0021-0033].

[837] Transcript of the Commission, 23 February 2024, T905.22-907.20 (Rechbauer); Transcript of the Commission, 26 February 2024 T1133.5-1134.40 (Levesque).

systematic way, nor does it oversee it. However, changes in some outcome measures may appear incidentally in data gathered for other purposes, such as work undertaken in relation to clinical variation and measures in place through clinical registries;[839]

c. none of the "deliverables" set out in the ACI's Service Agreement relate (at least expressly) to involvement it may have in the procurement of goods and services, other than a reporting requirement relating to its own procurement;[840]

d. the ACI's two most recent strategic plans do not identify any strategic or systematic function in respect of procurement, beyond the *ad hoc* role it may occasionally take (referred to above),[841] nor is the ACI referred to in the NSW Health Procurement Policy or Procedures; and

e. Adjunct Professor Levesque's statement of evidence, which was tendered in this Special Commission and comprehensively described the ACI's important role in relation to clinical innovations and models of care, used the word "procurement" only once, in the context of saying: "[p]rocurement practices can prevent local innovations from being taken to a stage where they are commercially viable."[842]

Clinical Excellence Commission

20.38. Similar to the position of the ACI, aside from regular meetings with HealthShare concerning supply chain issues (introduced in the wake of COVID-19), the CEC's involvement in procurement processes is also largely *ad hoc*.[843] Like the ACI, the CEC does not have a regular or routine role in procurement processes, and there does not appear to be any policy or procedure requiring tender evaluation committees considering tenders for the supply of clinical goods or services to seek input from it, nor does it have a "standing" membership of those committees.[844]

20.39. However, the CEC can become involved in procurement activities from time to time, including by:

a. leading responses to urgent, system level medicine, medical device, chemical and equipment shortages (including because of supply chain disruptions) to ensure clinical quality and safety;[845] and

[839] Transcript of the Commission, 26 February 2024, T1135.5-26 (Levesque).

[840] Exhibit B.23.49, Agency for Clinical Innovation, *Performance Agreement 2023-24* (31 October 2023) [MOH.0001.0284.0001 at 0001].

[841] See, for example, Exhibit B.23.56, Agency for Clinical Innovation, *Strategic Plan 2019-22* [MOH.0001.0281.0001]; Exhibit B.23.50, Agency for Clinical Innovation, *Strategic Plan 2023-2026* [MOH.0001.0350.0001 at 0020].

[842] Exhibit B.3, Statement of Adjunct Professor Jean-Frédéric Levesque (30 January 2024) [112f] [MOH.0001.0435.0001 at 0040].

[843] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [63] [MOH.0001.0434.0001 at 0021].

[844] Transcript of the Commission, 23 February 2024, T907.12-15 (Rechbauer).

[845] Exhibit B.2, Statement of Adjunct Professor Michael Nicholl (29 January 2024) [23]-[30] [MOH.0001.0262.0001 at 0006].

b. participating in Statewide procurement projects, such as the NSW Medicines Formulary, the SDPR and medical device reforms.[846]

Local organisations

20.40. A significant amount of the procurement activity in NSW Health occurs at the local organisational level, where most goods and services used across NSW Health are acquired.

20.41. Local organisations can conduct some procurement activities themselves, although once particular thresholds and conditions are met, they must be referred to HealthShare or eHealth, the effect of which is that:

a. if the goods or services (excluding professional services) to be procured are valued at $10,000 or less, the local organisation may procure them from any supplier, provided they meet all applicable quality, safety, security, and regulatory requirements, and their cost is reasonable and consistent with normal market rates;[847]

b. if the goods or services to be procured are valued at more than $10,000 and are available under a whole of NSW Health or whole of NSW Government contract, or a whole of NSW Government prequalification scheme or procurement list (essentially, a list of suppliers approved to supply particular goods or services to NSW Government agencies), the local organisation must use that arrangement (unless a procurement connected policy exemption or exemption granted by the Chief Procurement Office has been granted);[848] and

c. if the goods or services to be procured are not available under a whole of NSW Government or whole of NSW Health contract, or a whole of NSW Government prequalification scheme (including the ICT Services Scheme) or procurement list, the following apply:

i. if the goods or services to be procured are valued at more than $10,000 up to $30,000, the local organisation may procure the goods or services itself, by obtaining one written quote. NSW Health agencies must still meet applicable quality, safety, security, and regulatory requirements, and also check for any additional local arrangements;[849]

[846] Exhibit B.2, Statement of Adjunct Professor Michael Nicholl (29 January 2024) [31]-[33], [38]-[65] [MOH.0001.0262.0001 at 0007-0012].

[847] Exhibit B.23.13, NSW Health Procurement (Goods and Services) Policy (PD2023_028) (4 October 2023) p 9 cl 4.5 [MOH.0001.0037.0001 at 0013].

[848] Exhibit B.23.13, NSW Health Procurement (Goods and Services) Policy (PD2023_028) (4 October 2023) p 10 cls 5.1, 5.2 [MOH.0001.0037.0001 at 0014].

[849] Exhibit B.23.13, NSW Health Procurement (Goods and Services) Policy (PD2023_028) (4 October 2023) pp 13-14 cl 6.1.1 [MOH.0001.0037.0001 at 0017-0018].

ii. if the goods or services are valued at more than $30,000 up to $250,000 ($150,000 in the case of ICT goods or services), the local organisation may procure the goods or services itself, generally by an approach to market.[850] The nature of the approach to market required, and other requirements for the procurement (including whether a procurement plan and an evaluation plan are required, and the extent of the approach to market documentation required), depend on the outcome of a risk assessment conducted using the NSW Health "risk assessment tool";[851] and

iii. if goods or services are valued at more than $250,000 ($150,000 in the case of ICT goods or services), the local organisation must refer the procurement to HealthShare or eHealth as described above.[852]

20.42. The systems used by local organisations to undertake procurement activities are varied. Some local organisations have developed their own guidelines or manuals in an effort to make the processes easier to follow.[853] Most local organisations have their own internal procurement teams, which carry out some procurement tasks themselves and otherwise provide support to staff with that responsibility at the facility level.[854] They also have their own delegations for procurement activities.[855] The staff with delegations to perform procurement at the local level include clinical staff such as nurse unit managers, nurse practitioners and clinical educators.[856]

[850] Exhibit B.23.13, NSW Health Procurement (Goods and Services) Policy (PD2023_028) (4 October 2023) p 14 cl 6.1.2 [MOH.0001.0037.0001 at 0018].

[851] Exhibit B.23.13, NSW Health Procurement (Goods and Services) Policy (PD2023_028) (4 October 2023) p 14-22 cls 6.1.2, 6.2 - 6.18 [MOH.0001.0037.0001 at 0018-0026].

[852] Exhibit B.23.13, NSW Health Procurement (Goods and Services) Policy (PD2023_028) (4 October 2023) p 14 cl 6.1.2 [MOH.0001.0037.0001 at 0018].

[853] See for example, Exhibit B.23.145, Illawarra Shoalhaven Local Health District, *ISLHD Purchasing Manual* [MOH.0001.0446.0001]; Exhibit B.23.146, Illawarra Shoalhaven Local Health District, *Purchasing Matrix* [MOH.0001.0447.0001]; Exhibit B.23.163, South Western Sydney Local Health District, *SWSLHD Major Procurement Requirements and Guidelines: Tenders, Expressions of Interest, Contracts and State Contract Equipment Purchases* (10 May 2017) [MOH.0001.0270.0001]; Exhibit B.23.179, Southern NSW Local Health District, *Southern NSW LHD Procurement Guide* (September 2023) [MOH.0001.0457.0001]; See also, Exhibit B.1, Statement of Margot Mains (29 January 2024) [28] [MOH.0001.0260.0001 at 0011].

[854] See, for example, Exhibit B.1, Statement of Margot Mains (29 January 2024) [29]-[31] [MOH.0001.0260.0001 at 0012]; Exhibit B.4, Statement of Dr Teresa Anderson (31 January 2024) [21]-[22] [MOH.0001.0258.0001 at 0007-0008]; Exhibit B.7, Statement of Sonia Marshall (5 February 2024) [19]-[20] [MOH.0001.0261.0001 at 0006]; Exhibit B.8, Statement of Mark Spittal (6 February 2024) [28]-[29] [MOH.0001.0263.0001 at 0007]; Exhibit B.9, Statement of Margaret Bennett (9 February 2024) [21] [MOH.9999.0007.0001 at 0007-0008]; See also, Exhibit B.23.121, South Western Sydney Local Health District, *Procurement Team Structure* (undated) [MOH.0001.0399.0001].

[855] See, for example, Exhibit B.23.109, Illawarra Shoalhaven Local Health District, *Delegations Framework* (February 2021) [MOH.0001.0337.0001]; Exhibit B.23.114, Sydney Local Health District, *Delegations of Authority Manual* (28 June 2021) [MOH.0001.0412.0001]; Exhibit B.23.161, South Western Sydney Local Health District, *Delegations Manual* (September 2023) [MOH.0001.0268.0001]; Exhibit B.23.180, Southern NSW Local Health District, *Delegations of Authority Manual* (28 November 2023) [MOH.0001.0453.0001]; See also, Exhibit B.8, Statement of Mark Spittal (6 February 2024) [31] [MOH.0001.0263.0001 at 0007].

[856] See, for example, Exhibit B.14, Statement of Kylie Tastula (12 February 2024) [25] [SCI.0003.0001.0009 at 0012-0013]; Transcript of the Commission, 19 February 2024, T416.19-30 (Tastula).

20.43. Considering the range, complexity, and multilayered nature of the policies, processes, and systems governing the procurement within NSW Health, even with the launch of the "Procurement Academy" training modules for procurement staff and currently available user support mechanisms, it is perhaps understandable that staff at the local facility level often experience uncertainty, confusion, and frustration when attempting to procure non-routine items, such as medical consumables.[857] It is also not surprising that inconsistencies have arisen in procurement timeframes or outcomes in different places.[858] It would be undoubtedly frustrating for a clinician in one facility to see their colleagues in a different facility procuring the same item more quickly or efficiently.[859]

20.44. Complexity is inevitable in procurement that occurs within a system that is the size and scope NSW Health, particularly when those activities occur within a wider government context that also introduces a range of legislative and NSW Government requirements. It might also be that NSW Health's procurement reforms, including the "SmartChain" platform described below, will, over time, help with streamlining and simplification. But there are undoubted benefits in NSW Health continuing to:

a. consolidate its procurement policies, processes and systems where practicable;

b. provide clear, practical guidance to staff at all levels of the system (and not just procurement staff) as to the steps they need to take to procure different kinds of goods and services; and

c. ensure that assistance is readily available if staff experience difficulties.

Recent and ongoing procurement reforms

20.45. The consideration of NSW Health's procurement framework by this Special Commission has occurred in a context where NSW Health has been conducting a "reform" of that framework, the purpose of which is to deliver the change required to manage procurement more effectively, and to support value based healthcare across the system.[860]

[857] See, for example, Exhibit B.14, Statement of Kylie Tastula (12 February 2024) [12]-[25] [SCI.0003.0001.0009 at 0010-0013]; Transcript of the Commission 19 February 2024, T416.32-417.7 (Tastula); Transcript of the Commission, 23 February 2024, T991.17-26 (Gendy).

[858] See, for example, Exhibit B.14, Statement of Kylie Tastula (12 February 2024) [21], [24] [SCI.0003.0001.0009 at 0012].

[859] See, for example, Exhibit B.14, Statement of Kylie Tastula (12 February 2024) [24] [SCI.0003.0001.0009 at 0012]; Transcript of the Commission, 19 February 2024, T409.13-28, T410.30-411.14 (Tastula); Exhibit B.1, Statement of Margot Mains (29 January 2024) [73] [MOH.0001.0260.0001 at 0021]; Exhibit B.4, Statement of Dr Teresa Anderson (31 January 2024) [120] [MOH.0001.0258.0001 at 0031].

[860] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [93], [96] [MOH.0001.0434.0001 at 0031, 0034].

20.46. That reform program involves four "workstreams":

a. Operating Model: This workstream involves the implementation of a new "Operating Model",[861] which includes investment in additional staffing in contract implementation and management roles across HealthShare, eHealth and NSW Health Pathology, as well as the clarification of roles and responsibilities of existing procurement staff, a new Contract Management Framework, and new procurement "dashboards" for procurement spending, as well as updates to the "risk assessment tool";[862]

b. NSW Medicines Formulary: A "holistic framework governing the procurement and usage of pharmaceuticals" across NSW public hospital inpatients and NSW Ambulance.[863] It involves a consolidation of 27 different formularies and 60 different governance groups for reviewing formulary submissions into one, with one peak governing body, as well as reduction of medicines in the formulary by more than two thirds;[864]

c. DeliverEASE: This is a reform focussed on the medical consumables supply chain. In addition to simplifying the ordering process, DeliverEASE improves inventory management,[865] and standardises storeroom layouts across NSW Health facilities;[866] and

d. SmartChain: The aim of SmartChain is to create a single, Statewide, end to end procurement platform for all procurement and supply chain activities in NSW Health, including pricing, ordering, and inventory monitoring.[867] SmartChain will include five modules. One of those – "Traceability", a tracking system for implantable and prosthetic products and devices used for patients[868] – has been rolled out.[869]

[862] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [30(a)], [64(a)], [95(b)] [MOH.0001.0434.0001 at 0006, 0021, 0034]; See also, Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [113] [MOH.9999.0009.0001 at 0031].

[863] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [30(b)], [64(b)] [MOH.0001.0434.0001 at 0006, 0022]; Exhibit B.2, Statement of Adjunct Professor Michael Nicholl (29 January 2024) [38]-[65] [MOH.0001.0262.0001 at 0007-0012].

[864] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [95(a)(iii)]-[95(a)(iv)] [MOH.0001.0434.0001 at 0033].

[865] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [30(c)], [64(c)] [MOH.0001.0434.0001 at 0006, 0022]; See also, Exhibit B.1, Statement of Margot Mains (29 January 2024) [69] [MOH.0001.0260.0001 at 0020]; Transcript of the Commission, 1 February 2024, T667.31-668.10 (Chiumento).

[866] Transcript of the Commission, 23 February 2024, T993.36-994.16 (Gendy); Transcript of the Commission, 21 February 2024, T668.12-28 (Chiumento).

[867] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [30d], [64e], [65] [MOH.0001.0434.0001 at 007, 0022].

[868] See, for example, Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [114] [MOH.9999.0009.0001 at 0031]; Transcript of the Commission, 21 February 2024, T669.8-671.26 (Chiumento).

[869] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [66] [MOH.0001.0434.0001 at 0023].

Value based procurement

Conceptions of value

20.47. As noted above, one of the five objectives of procurement identified in the NSW Government *Procurement Policy Framework* – and the one that is "the overarching consideration for government procurement" – is "value for money".[870] The Framework describes "value for money" in the following way: [871]

> *Value for money is not necessarily the lowest price, nor the highest quality good or service. It requires a balanced assessment of a range of financial and non-financial factors, such as: quality, cost, fitness for purpose, capability, capacity, risk, total cost of ownership or other relevant factors.*

20.48. NSW Health translates the concept of value for money into a health setting through the concept of value based healthcare.[872] This is reflected in one of the "key objectives" in the *Future Health Plan*, which is to "[d]rive value-based healthcare that prioritises outcomes and collaboration".[873] "Value-based healthcare" is said to mean:

> *continually striving to deliver care that improves the health outcomes that matter to patients, patient experiences of receiving care, clinician experiences of providing care as well as the effectiveness and efficiency of care.*[874]

20.49. This is said to require a shift in focus away from those matters that incentivise gains in technical efficiency, that are inherent in volume or activity based funding, towards "care that focuses on outcomes".[875]

20.50. The definition of value based healthcare in the *Future Health Plan* incorporates outcomes and experiences (of both patients and clinicians). That is consistent with the ACI's approach to value based healthcare set out in its *Value-based surgery: Clinical practice guide*:[876]

[870] Exhibit B.23.16, NSW Government, *Procurement Policy Framework* (April 2022) p 9 [MOH.0001.0132.0001 at 0009].

[871] Exhibit B.23.16, NSW Government, *Procurement Policy Framework* (April 2022) p 9 [MOH.0001.0132.0001 at 0009].

[872] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [40] [MOH.0001.0434.0001 at 0009-0010].

[873] Exhibit B.23.23, NSW Health, *Future Health: Guiding the next decade of health care in NSW 2022-2032* (May 2022) p 16 [MOH.0001.0320.0001 at 0016].

[874] Exhibit B.23.23, NSW Health, *Future Health: Guiding the next decade of health care in NSW 2022-2032* (May 2022) pp 16 [MOH.0001.0320.0001 at 0016].

[875] Exhibit B.23.23, NSW Health, *Future Health: Guiding the next decade of health care in NSW 2022-2032* (May 2022) p 16 [MOH.0001.0320.0001 at 0016].

[876] Exhibit B.23.64, Agency for Clinical Innovation, *Value-based surgery: Clinical practice guide* (November 2023) p 4 [MOH.0001.0282.0001 at 0007]; See also, Exhibit B.59, NSW Health, *Leading Better Value Care* (December 2019) p 3 [SCI.0003.0021.0001 at 0003].

> *In NSW, value-based healthcare means continually striving to deliver care that improves:*
>
> - *health outcomes that matter to patients*
> - *the experience of receiving care*
> - *experiences of providing care*
> - *effectiveness and efficiency of care.*
>
> *Value-based healthcare requires a collaborative approach to ensure best outcomes for patients and the best value for the system.*

20.51. Dr Teresa Anderson, then Chief Executive of Sydney LHD, described value based health outcomes in a similar way: [877]

> *So this is really about making sure that we get value out of the contracts, not just in terms of savings, financial savings, but improved outcomes for our patients and the experience of our staff, helping to streamline the processes for our staff.*

20.52. Other definitions of value based healthcare focus primarily on "outcomes". For example:

a. the NSW Health Procurement Procedures refer to value based healthcare as taking "an outcomes-based approach";[878]

b. Alira Health, in a report titled *Value-Based Procurement in Australia* commissioned for the Medical Technology Association of Australia (MTAA) – which advocates for a value based approach to procurement – defined value based healthcare as "the improved health outcomes for patients versus the total costs of delivering care", and value based procurement as having a corresponding meaning;[879]

c. Paul Dale, Director, Policy of the MTAA, described value based healthcare as "delivering the outcomes that matter to patients as efficiently as possible", although he also referred to the experience of the patient;[880]

[877] Transcript of the Commission, 21 February 2024, T726.46-727.4 (Anderson).

[878] Exhibit B.23.14, NSW Health Procurement Procedures (Goods and Services) (June 2022) p 37 cl 6.13.2 [MOH.0001.0366.0001 at 0037].

[879] Exhibit B.18, Alira Health, *Value-Based Procurement in Australia* p 6 [SCI.0003.0001.0048 at 0053].

[880] Transcript of the Commission, 20 February 2024, T612.11-18 (Dale).

d. Carmen Rechbauer, then Chief Executive of HealthShare NSW, ultimately described the concept as requiring consideration not just of price but of "all other aspects that go into being able to provide safe products for patients";[881] and

e. Michael Gendy, Chief Procurement Officer, Ministry of Health, described value based healthcare as follows:[882]

> *Value based health care for me is all about patient outcomes and the primary focus of that is the outcomes that we can achieve for our patients. Everything that we do is all for our patients.*

20.53. Mr Gendy emphasised that value was not synonymous with "price".[883] However, he saw value as interacting with economic efficiency. For example, procurement reforms with the effect of reducing cost and freeing up staff would, in turn, allow money and staff time to be redirected to better achieving patient outcomes.[884] Similarly, Mr Dale's view was that, while value based healthcare must be patient centric, "there's an efficiency component as well, so delivering the maximum outcome for the resources that you are using".[885]

20.54. What these conceptions of value based healthcare have in common is the aim of delivering the most valuable healthcare for a given cost. There is a general consensus that this should be the underlying intent of procurement activities (and probably any expenditure) in the health system. The aim should not merely be to achieve the lowest price for the type of good or service to be acquired.

20.55. Identifying what represents value in that context, or formulating robust processes for identifying it, is less straightforward. Although there is a consensus that value based healthcare must involve, at some level, or be linked to, achieving good patient outcomes, what amounts to "good" patient outcomes is not always the subject of clear or easy identification.

20.56. It appears to be accepted that the concept should not be limited to an objectively successful clinical outcome but may also encompass, for example, whether the provision of care achieved what the patient wanted to achieve from it, and whether the patient is happy with how they were treated. Quantifying value should also involve consideration of the position of the broader system; including the interests of clinicians, and the wider system impacts of resource allocations.

[881] Transcript of the Commission, 23 February 2024, T916.10-16 (Rechbauer).

[882] Transcript of the Commission, 23 February 2024, T1002.11-14 (Gendy).

[883] Transcript of the Commission, 23 February 2024, T1002.16-23 (Gendy).

[884] Transcript of the Commission, 23 February 2024, T1002.16-1003.14 (Gendy).

[885] Transcript of the Commission, 20 February 2024, T612.18-20 (Dale).

20.57. Accordingly, the concept of value in healthcare should involve a consideration of value not just to an individual patient and those with a direct stake in their care, but to other stakeholders in the system including clinicians and the broader community.

20.58. It would be futile for me to attempt to formulate a definition of value that should be applied to all procurement activities across NSW Health. In each case, what must be considered in the assessment of value will turn on the particular good or service, its use, and the context in which the procurement occurs. What is important, though, is that there is a systematic approach to identifying and assessing value in the context of procurement activities that seek to support the notion of value based healthcare.

20.59. That is not presently occurring, or at least not in a systemic and regular way, across NSW Health's procurement activities.

Embedding an assessment of value in procurement activities

20.60. Despite an extensive range of policies, procedures, guidelines, frameworks, and similar documents relating to procurement, none describes how value is to be assessed and achieved in any given procurement process.

20.61. The main way in which value appears to be assessed in NSW Health's procurement processes is through the criteria applied in evaluating tenders. These criteria are set out in a procurement plan. They may, depending on the subject matter of the tender, include value related criteria such as the extent to which the product or service will achieve certain patient outcomes. Expertise is brought to bear on these criteria during the tender evaluation process through clinicians or other subject matter experts participating as members of the tender evaluation committee, or by providing feedback to contract managers or clinical product managers who are expected to pass on that feedback.[886]

20.62. However, there does not appear to be any documented method or system by which value related criteria are to be determined and incorporated into a procurement plan or tender evaluation process. For example, Ms Rechbauer was not aware of whether there was any formal process by which tender evaluation committees weighted value based considerations such as patient outcomes,[887] nor whether such considerations were recorded or communicated, but said the brief produced for her approval – as one of the individuals with responsibility for signing off the award of a contract – would not include that level of detail.[888] In its written submissions, NSW Health accepted – as is clear from the evidence – that there were "opportunities to improve in this area".[889]

[886] Transcript of the Commission, 23 February 2024, T901.13-904.42 (Rechbauer), T1007.15-1009.35, T1013.35-38 (Gendy).

[887] Transcript of the Commission, 23 February 2024, T910.3-911.9 (Rechbauer).

[888] Transcript of the Commission, 23 February 2024, T910.3-911.9 (Rechbauer).

[889] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [12.8] [SCI.0011.0814.0001 at 0116].

20.63. Further, the incorporation of clinical feedback into the evaluation of tenders is heavily dependent on whether clinicians have provided feedback to the relevant category managers or clinical product managers which was then passed on and taken into account in the tender evaluation process;[890] and whether clinicians happened to be available and selected as LHD representatives on tender evaluation committees.[891] While clinicians at the LHD level may be involved in tender processes, they do not ordinarily have input into the negotiation of a contract, which can lead to problems later.[892]

20.64. In its written submissions addressing this issue, NSW Health accepted that there is an "opportunity" to better document the importance of engaging clinical expertise throughout the lifecycle of a procurement process, not only at the planning stages, but during the product specification and negotiation phases. [893] Once again, I agree.

20.65. As noted above, whether the ACI or CEC becomes involved in a particular tender process is *ad hoc*, and seemingly up to the individual tender evaluation committee to decide.[894] In its written submissions, NSW Health recognise this as:[895]

> *an area of future opportunity, whereby HealthShare NSW can work with Ministry, Agency for Clinical Innovation and Clinical Excellence Commission to test how value-based healthcare can better be integrated into procurement processes from end to end.*

20.66. The current approach to value in NSW Health procurement processes might result in some tenders being conducted in a way that supports and promotes value based healthcare. But the absence of a documented and systematic approach to the consideration of value based measures and factors means there are currently no processes, plans or structures in place to ensure that this occurs consistently.

20.67. Those difficulties do not only arise in the context of tenders. No specific guidance is given on how to assess concepts of value when procuring lower value goods or services on PCards or VCards, [896] or when local organisations procure goods or services on established whole of NSW Government or whole of NSW Health contracts. It is obviously desirable to balance the need to include value based

[890] Transcript of the Commission, 23 February 2024, T902.41-904.42 (Rechbauer).

[891] Transcript of the Commission, 23 February 2024, T904.44-907.40 (Rechbauer).

[892] Transcript of the Commission, 21 February 2024, T702.7-35 (Kokkinakos), T727.21-728.13 (Anderson).

[893] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [12.11] [SCI.0011.0814.0001 at 0117-0118].

[894] Transcript of the Commission, 23 February 2024, T906.35-907.20 (Rechbauer).

[895] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [12.12] [SCI.0011.0814.0001 at 0118].

[896] See Exhibit B.23.32, *PD2022_038 Procurement Cards within NSW Health* (2 September 2022) p 6 [MOH.0001.0298.0001 at 0009]: Procurement Cards (PCards) are a credit card issued by the Card Issuer (generally a bank, building society or credit union) which is used by Cardholders (as government officers) to engage in transactions relating to the purchase of goods and services on behalf of the GSF agency; and Virtual Cards (VCards) are a credit card that is not issued as a physical card, rather a 16-digit number provided to a supplier for use in card-not-present transactions. The VCard card is not linked to a Cardholder but is established in the GSF agency's name (with one or many users).

considerations into procurement activities, and the need for much of it to occur at the local level as quickly and efficiently as possible. However, currently, there does not appear to have been any substantive attempt to strike that balance for procurement activities that do not involve a tender process.

20.68. There are also limited structures for supplier engagement and feedback that might support a more detailed assessment of value. In this respect, suppliers report receiving limited guidance from NSW Health for advancing value based product offerings.[897] Attempts to do so have been met, both in HealthShare and at the LHD level, with a continued "strong focus" on achieving the lowest price or cost.[898]

20.69. Two primary pathways by which a supplier could bring to the attention of NSW Health an advance or development in medical technology that could benefit NSW patients were identified by Mr Gendy. They are: by a representative of the supplier raising it with a clinician within the system, or during the process of "refreshing" standing offer agreements, which enables new technologies to be added through the supplier panel.[899] Both are somewhat *ad hoc*, although the proposed "supplier forums" (if pursued) appear likely to promote better dialogue between NSW Health representatives and suppliers in relation to future procurement activities and offerings.[900]

20.70. That HealthShare has not (to date) engaged in a process of systematically embedding value based healthcare into its procurement processes is likely to have been at least partly a function of the fact that the KPIs set out in its Statement of Service do not require it to do so in any substantive way. While one of the "achievement statements" in its *2023–24 Statement of Service* is that "[s]uccessful [value-based healthcare] initiatives are scaled and applied at a local and State level", only one of the three "actions" directed to that achievement relates to procurement, which requires HealthShare to:[901]

> *[c]omplete a refresh of all Procurement category strategies with input from across the system including identification of opportunities to drive better value and eliminate inefficiencies.*

20.71. Further, while the *2024–25 Statement of Service* for HealthShare refers to the *Future Health Strategic Framework*, it does not include any statements of achievement or delivery actions that refer to value.[902]

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[897] Exhibit B.16, Statement of Paul Dale (14 February 2024) [4.1]-[4.3] [SCI.0003.0001.0022 at 0024-0025].

[898] Exhibit B.16, Statement of Paul Dale (14 February 2024) [2.1.1.1] [SCI.0003.0001.0022 at 0023]; Transcript of the Commission, 20 February 2024, T617.30-618.39 (Dale).

[899] Transcript of the Commission, 23 February 2024, T1015.1-35 (Gendy).

[900] Transcript of the Commission, 23 February 2024, T913.6-20 (Rechbauer), 1014.12-37 (Gendy).

[901] Exhibit B.23.129, *HealthShare NSW Statement of Service 2023-24* (9 February 2024) p 19 cl 6.1.1.1.20 [MOH.9999.0010.0001 at 0020].

902 Exhibit O.67, *HealthShare NSW Statement of Service 2024-25* (9 August 2024) [SCI.0011.0895.0001].

20.72. There are some local initiatives in some LHDs that seek to build value based healthcare into their local procurement processes. For example, South Western Sydney LHD has established a Strategic Advisory Procurement Board, which is tasked with advising and decision making on "strategic and value based procurement of goods and services including redevelopment activity, asset replacement, and ICT".[903] One of the matters that the Board must consider for a procurement proposal is "healthcare centred solutions with clinical engagement and evaluation".[904] That is sought to be achieved through the Board being required to consider not only the financial cost of a proposed procurement activity, but also whether it will achieve value, which is assessed by reference to the nature of the good or service in question.[905] The Board has at least two members with a clinical background,[906] and category managers generally consult with relevant clinical staff before presenting a proposal.[907]

20.73. However, the extent to which the Strategic Advisory Procurement Board is effective in implementing value based healthcare in South Western Sydney LHD's procurement processes is not entirely clear, and it is apparent that its activities are heavily focussed on limiting costs and achieving savings and efficiencies.[908] It is understandable, in the environment of intense budgetary pressure that prevails within NSW Health, that local procurement activities will be heavily influenced by financial savings and efficiencies, even in circumstances where effort is made to incorporate value based healthcare.

20.74. That only serves to highlight the need for the Ministry of Health and HealthShare to communicate clearly what the concept value based healthcare entails, and how it should be measured and assessed, to those with responsibility for procurement across the system, from facility and service levels up. Those principles must be embedded in a systematic manner throughout every level of procurement processes within NSW Health, rather than by local organisations adopting their own approach. That is not to say that what constitutes value will not be informed by local considerations and needs. But if there is to be a consistent, system wide approach to procurement (and healthcare spending generally) that supports the pursuit of value based healthcare, there must be clear guidance on what that means, and how it is to be assessed and measured.

[903] Exhibit B.23.122, South Western Sydney Local Health District, *Terms of Reference – SWSLHD Strategic Procurement Advisory Board (SPAB)* (October 2022) cl 6 [MOH.0001.0423.0001 at 0002].

[904] Exhibit B.23.122, South Western Sydney Local Health District, *Terms of Reference – SWSLHD Strategic Procurement Advisory Board (SPAB)* (October 2022) cl 7 [MOH.0001.0423.0001 at 0002].

[905] Transcript of the Commission, 22 February 2024, T802.46-803.41 (Marshall).

[906] Exhibit B.23.122, South Western Sydney Local Health District, *Terms of Reference – SWSLHD Strategic Procurement Advisory Board (SPAB)* (October 2022) cl 2 [MOH.0001.0423.0001 at 0001].

[907] Transcript of the Commission, 22 February 2024, T801.23-34 (Marshall).

[908] Transcript of the Commission, 22 February 2024, T774.10-33 (Clancy).

20.75. That is squarely within the remit of the Ministry of Health as system manager to drive forward. It has been done in other contexts. The ACI's *Value-based surgery: Clinical practice guide* describes a process for implementing value based care in surgical practice, including matters such as consultation requirements.[909]

Equity in procurement

20.76. The means by which equity in procurement – both in the sense of health equity and equity in the participation in the procurement process – is to be achieved across NSW Health agencies is somewhat unclear. For example:

a. there are no substantive references to equity in the NSW Health Procurement Policy or Procedures;[910]

b. there is no specific reference to procurement in the *Regional Health Strategic Plan*, except in the context of environmental sustainability;[911]

c. aside from referring to the general objectives in the *Future Health Plan* and *Regional Health Plan*, the only express reference to equity with any specified action in HealthShare's *2023–24 Statement of Service* is in the context of measuring "timely and equitable access" to services, for which the only specified action is developing and implementing dashboards for the Patient Transport Service (that is, nothing to do with procurement);[912]

d. little has changed in its *2024–25 Statement of Service*, in which the only reference to equity is the context of influencing the redesign of services to achieve health equity among the First Nations population;[913] and

e. equity is not a concept that appears at all in HealthShare's most recent strategic plan.[914]

20.77. This is not to say that NSW Health does not take the concept of equity seriously.

20.78. A key objective in the *Future Health Plan* is to "[s]trengthen equitable outcomes and access for rural, regional and priority populations".[915] Similarly, NSW Health's *NSW Regional Health Strategic Plan 2022–2032* is dedicated to NSW Health's vision for

[909] Exhibit B.23.64, NSW Agency for Clinical Innovation, *Clinical Practice Guide Value-Based Surgery* (November 2023) [MOH.0001.0282.0001].

[910] Exhibit B.23.13, NSW Health Procurement (Goods and Services) Policy (PD2023_028) (4 October 2023) pp 20-21 cl 6.14 [MOH.0001.0037.0001 at 0024-0025]; Exhibit B.23.14, NSW Health Procurement Procedures (Goods and Services) (June 2022) p 46 cl 6.17.4 [MOH.0001.0366.0001 at 0046].

[911] Exhibit B.23.24, NSW Health, *NSW Regional Health Strategic Plan 2022-2032* (February 2023) pp 63, 67 [MOH.0001.0372.0001 at 0063, 0067].

[912] Exhibit B.23.129, HealthShare NSW, *Statement of Service 2023-24* (9 February 2024) p 17 cl 2.1.1.1.10 [MOH.9999.0010.0001 at 0018].

[913] Exhibit O.67, *HealthShare NSW Statement of Service 2024-25* (9 August 2024) p 5 [SCI.0011.0895.0001 at 0006].

[914] Exhibit B.23.38, HealthShare NSW, *Strategic Plan 2020-2024* (13 October 2020) [MOH.0001.0328.0001].

[915] Exhibit B.23.23, NSW Health, *Future Health: Guiding the next decade of health care in NSW 2022-2032* (May 2022) p 8 [MOH.0001.0320.0001 at 0008].

"[a] sustainable, equitable and integrated health system delivering outcomes that matter most to patients and the community in regional, rural and remote NSW".[916] There have also been several initiatives that promote equity of access to services across the State, including virtual health care.[917] The recent NSW Medicines Formulary project also had as one of its aims equity of access to medicines for all patients in NSW.

20.79. There are also several initiatives (including at the State level) directed to equitable participation in procurement processes by Aboriginal businesses (i.e., one that has at least 50 per cent Aboriginal ownership).[918] Consistent with that approach, NSW Health has developed its own *Aboriginal Procurement Participation Strategy*,[919] and HealthShare has, (for some time) included a requirement for Aboriginal Participation Plans in relation to all goods and services over a certain threshold.[920] Similarly, the *NSW Government Small and Medium Enterprise and Regional Procurement Policy* seeks to increase procurement opportunities for small and medium enterprises, including those in the regions, across NSW Government procurement activities.[921] All of those State level policies must be adhered to by NSW Health in its procurement activities.[922]

20.80. However, equity – whether of access to health services or in the procurement processes itself – is not a concept that seems to have been systematically embedded across the breadth of NSW Health's procurement processes. As much was seemingly accepted by NSW Health in its written submissions, when it accepted that there was "scope" for further analysis of the use of its purchasing power to better achieve equity in the system.[923]

20.81. One reason why that has not occurred to date is that it has been seemingly assumed that increasing centralisation of procurement will inevitably lead to greater equity. In this respect, Mr Gendy gave evidence that:[924]

> *Centralised procurement also enables greater savings to be achieved by harnessing system purchasing power to obtain whole of health volume discounts from suppliers, which enables equitable procurement across geographic areas.*

[916] Exhibit B.23.24, NSW Health, *NSW Regional Health Strategic Plan 2022-2032* (February 2023) p 14 [MOH.0001.0372.0001 at 0014].

[917] See, for example, Exhibit B.23.67, NSW Health, *NSW Virtual Care Strategy 2021-2026* (February 2022) [MOH.0001.0371.0001].

[918] Exhibit B.23.21, *NSW Government Aboriginal Procurement Policy* p 2 (January 2021) [MOH.0001.0277.0001 at 0004].

[919] Exhibit B.23.115, *NSW Health Aboriginal Procurement Participation Strategy* (March 2022) [MOH.0001.0276.0001]

[920] Exhibit B.23.115, *NSW Health Aboriginal Procurement Participation Strategy* (March 2022), p 4 [MOH.0001.0276.0001 at 0006].

[921] Exhibit B.23.18, *NSW Government Small and Medium Enterprise and Regional Procurement Policy* p 6 [MOH.0001.0417.0001 at 0006].

[922] Exhibit B.5, Statement of Michael Gendy (31 January 2024), [46], [78], [79] [MOH.0001.0434.0001 at 0012, 0027-0028].

[923] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [12.15] [SCI.0011.0814.0001 at 0119].

[924] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [87] [MOH.0001.0434.0001 at 0030].

20.82. Similarly, Ms Rechbauer referred (albeit in the context of other shared services) to increasing "service equity across metropolitan and regional LHDs" by increasing centralisation and standardisation of those services.[925] She was insistent when giving evidence that Statewide contracts achieve "the best price for the State" and thereby "maximise equity across the system over time".[926]

20.83. The proposition that Statewide or whole of health contracts result in the best price across the system appears to be based on the logic that the State (represented by HealthShare) has greater purchasing power, and therefore greater negotiating power, than individual LHDs or other local organisations negotiating separately.[927]

20.84. There is a natural attraction to that proposition. But it is not apparent that the underlying premise holds in the context of the wider public health system in this State, or that it has been meaningfully tested. For example, there is a view held by some metropolitan LHDs that they could achieve lower prices for some products and services if they were at liberty to procure them directly.[928] Mr Gendy said that if an LHD approached him with evidence that it was worse off under a Statewide contract, then he would "look at how we can adjust that", although his view remained that the system as a whole would be better off because of the Statewide contract.[929] Similarly, Ms Rechbauer's evidence was that there may be occasions on which a supplier is permitted to offer a lower price to a particular local organisation under a Statewide contract, but this would need to come through HealthShare, and would be determined by HealthShare on an *ad hoc* basis having regard to "how that will impact the system".[930] The extent to which this actually occurs, or how it is determined whether or to what extent differential pricing "will impact the system", is not apparent.

20.85. There are also aspects of the current approach that might be said to leave rural and regional LHDs in a worse position. For example, in relation to goods supplied through the Onelink warehouse, non-metropolitan LHDs bear the cost of transporting goods from the warehouse to their facilities.[931] There is evidence that some suppliers are unwilling or unable (at least in a timely way) to supply to rural and remote facilities

[925] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [125]-[126] [MOH.9999.0009.0001 at 0034].

[926] Transcript of the Commission, 23 February 2024, T894.10-33 (Rechbauer).

[927] See, for example, Transcript of the Commission, 23 February 2024, T894.45-895.11 (Rechbauer).

[928] See, for example, Exhibit B.4, Statement of Dr Teresa Anderson AM (31 January 2024) [114] [MOH.0001.0258.0001 at 0030]; Exhibit B.7, Statement of Sonia Marshall (5 February 2024) [46] [MOH.0001.0261.0001 at 0011]; Transcript of the Commission, 21 February 2024, T746.46-747.26 (Anderson); Transcript of the Commission, 22 February 2024, T781.44-782.44 (Clancy), T813.38-815.14 (Marshall).

[929] Transcript of the Commission, 23 February 2024, T1006.41-1007.13 (Gendy).

[930] Transcript of the Commission, 22 February 2024, T887.4-889.16 (Rechbauer); Transcript of the Commission, 23 February 2024, T895.13-30 (Rechbauer).

[931] See, for example, Exhibit B.8, Statement of Mark Spittal (6 February 2024) [69]-[71] [MOH.0001.0263.0001 at 0015-0016]; Exhibit B.9, Statement of Margaret Bennett (9 February 2024) [55] [MOH.9999.0007.0001 at 0016]; Transcript of the Commission, 23 February 2024, T896.44-897.30 (Rechbauer).

despite being under Statewide contracts.[932] In these circumstances, Statewide contracts do not appear to be achieving equity.

20.86. It may be that Statewide contracts with a uniform pricing structure are, in fact, the best available means of achieving equity in procurement at a system wide level. There may also be other benefits to standardisation that can only be achieved by such an arrangement. While there will inevitably be "swings and roundabouts", the overall benefit to the system might justify such an approach. But these matters cannot be assumed. Having regard to the size of the procurement activities conducted across NSW Health, they must be tested and monitored through careful modelling and analysis. Through such modelling and analysis of its procurement strategies, NSW Health should be in a position to properly assess whether its approach has promoted equity across the system.

20.87. Ultimately, the principal object of centralised procurement should be to ensure that NSW Health achieves the best value for money spent. Only through careful modelling will it be possible for HealthShare to determine which arrangement will deliver greatest value to the entire system. If that arrangement results in rural and remote LHDs paying more for a particular item, or incurring significant freight costs in having goods delivered from a centralised warehouse, it may be that equity can only be achieved through adjustments to the funding provided to those LHDs, rather than seeking to equalise pricing through procurement in a manner that risks system wide value.

Measuring the effectiveness of procurement

20.88. Any gains that may be made through improvements in processes, including through embedded principles of value, are at risk of being lost unless there are robust processes to monitor performance, and manage suppliers. These post procurement processes of monitoring and evaluation – often referred to as being within the realm of "contract management" – are "a crucial part of the procurement lifecycle".[933]

20.89. That contract management function is generally conducted by the entity with responsibility for the contract. This means whole of NSW Government contracts relevant to NSW Health, or whole of NSW Health contracts are managed by HealthShare, except those relating to ICT, which are managed by eHealth.[934] HealthShare also has a role in managing contracts for which it tenders on behalf of a

[932] Exhibit B.8, Statement of Mark Spittal (6 February 2024) [71] [MOH.0001.0263.0001 at 0016]; Exhibit B.9, Statement of Margaret Bennett (9 February 2024) [53] [MOH.9999.0007.0001 at 0015].

[933] Transcript of the Commission, 23 February 2024, T1013.3-4 (Gendy).

[934] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [49] [MOH.9999.0009.0001 at 0015]; Exhibit B.6, Statement of Dr Zoran Bolevich (31 January 2024) [69] [MOH.0001.0433.0001 at 0029]; Transcript of the Commission, 23 February 2024, T1010.36-1011.5 (Gendy).

local organisation (generally contracts exceeding $250,000 in value).[935] Local contracts are otherwise managed by the relevant local organisation.

20.90. An immediate difficulty is that those responsibilities of HealthShare and eHealth are not clearly formalised or outlined. Neither the HealthShare Board's delegation of functions[936] nor eHealth's determination of functions[937] refers expressly to contract management as one of their functions or responsibilities. It is not a concept that appears in either organisation's most recent strategic plans except, in eHealth's case, for a high level reference to seeking to achieve "a more adaptive approach to vendor management".[938] At least on their face, none of HealthShare's "Procurement and Supply Chain KPIs" in its most recent Statement of Service measure its effectiveness in contract management,[939] and there is no specific reference to contract management at all.[940] The section of the NSW Health Procurement Policy dealing with contract management is mostly addressed to local agencies, with little reference to HealthShare or eHealth.[941]

20.91. However, the NSW Health Procurement Procedures contemplate HealthShare and eHealth being involved in contract management, and set out detailed procedures that those responsible for contract management are supposed to follow (including monitoring performance).[942] Given a core function of those organisations is procurement, their role in the critical areas of contract and supplier performance management should be clearly set out in their Statements of Service and reflected in measurable KPIs, not a procedural document.

20.92. In any event, the evidence supports a conclusion that the "contract management" functions of HealthShare and eHealth need to be strengthened. In this respect, while HealthShare has regular meetings with suppliers,[943] there is presently no substantive system wide monitoring of the extent to which suppliers are complying with KPIs in their respective contracts.[944] Instead, issues with suppliers generally make their way to HealthShare only when raised from the local organisation or facility level, which

[935] Exhibit B.11, Statement of Carmen Rechbauer (12 February 2024) [31(c)], [119] [MOH.9999.0009.0001 at 0011, 0032]; Transcript of the Commission, 22 February 2024, T880.15-23 (Rechbauer).

[936] Exhibit B.23.37, Delegation of Functions of the Healthcare Board (29 November 2012) [MOH.0001.0308.0001].

[937] Exhibit B.23.124, Instrument of Establishment – eHealth NSW (2 June 2023) [MOH.0001.0312.0001].

[938] Exhibit B.23.66, NSW Health, *eHealth Strategy for NSW Health 2016-2026* p 12 [MOH.0001.0254.0001 at 0016]; See also, Exhibit B.23.38, HealthShare NSW, *Strategic Plan 2020-2024* (13 October 2020) [MOH.0001.0328.0001].

[939] Exhibit O.67, HealthShare NSW, *Statement of Service 2024-25* (9 August 2024) p 13 [SCI.0011.0895.0001 at 0014].

[940] Exhibit O.67, HealthShare NSW, *Statement of Service 2024-25* (9 August 2024) [SCI.0011.0895.0001].

[941] Exhibit B.23.13, NSW Health Procurement (Goods and Services) Policy (PD2023_028) (4 October 2023) cl 7 [MOH.0001.0037.0001 at 0026-0031].

[942] Exhibit B.23.14, NSW Health Procurement Procedures (Goods and Services) (June 2022) pp 51-67 s 7 [MOH.0001.0366.0001 at 0051-0067].

[943] See, for example, Transcript of the Commission, 23 February 2024, T902.11-19 (Rechbauer).

[944] Transcript of the Commission, 23 February 2024, T902.41-904.42 (Rechbauer), T1011.20-22 (Gendy).

generally occurs only when the problem has become serious.[945] Even in those circumstances, HealthShare's responsiveness is perceived as being variable.[946]

20.93. To the extent there is monitoring of supplier KPIs by HealthShare, those with responsibility for procurement at the local level do not receive adequate feedback or have adequate visibility of data about the performance of Statewide suppliers, or even, at least in some cases, what their KPIs are.[947] That significantly limits their ability to identify instances of poor performance, the effects of which are borne by the local organisation.[948]

20.94. There is also no clear process or method for evaluating whether the procurement actually achieved value. While, as set out above, notions of value are considered as part of tender evaluations,[949] there does not appear to be any clear approach or method by which an assessment is made as to whether that value was ultimately delivered. Ms Rechbauer did not know whether there was any process for monitoring particular outcomes that may have been important in the decision making for a procurement activity, or whether local organisations were instructed to do so.[950] Similarly, Mr Gendy said that he was not involved in monitoring the effectiveness of procurement in achieving patient outcomes, including those outcomes that may have been featured in the tender evaluation process.[951]

20.95. The NSW Health Procurement Procedures, which provide the most detailed guidance to local organisations about their contract management responsibilities, do not refer expressly to monitoring whether a contract has actually achieved value in any relevant sense. What they require is that contract managers monitor and review "contractual performance measures".[952]

20.96. In October 2019, the NSW Auditor-General reported to Parliament in October 2019 that, among other things, HealthShare "is not applying the capability needed to effectively manage high-value (over $250,000) goods and services contracts", and was not complying with the directions given to it by the Ministry of Health in relation

[945] See, for example, Transcript of the Commission, 20 February 2024, T640.18-26 (Misevska), 775.39-47 (Clancy); See also, Transcript of the Commission, 23 February 2024, T920.41-921.31, T938.34-939.29 (Rechbauer), T1011.7-13 (Gendy).

[946] See, for example, Transcript of the Commission, 21 February 2024, T757.36-758.4, T769.42-770.5 (Swingler), T715.26-32 (Kokkinakos); cf Transcript of the Commission, 22 February 2024, T777.15-21 (Clancy).

[947] See, for example, Exhibit B.1, Statement of Margot Mains (29 January 2024) [88] [MOH.0001.0260.0001 at 0025]; Exhibit B.7, Statement of Sonia Marshall (5 February 2024) [52] [MOH.0001.0261.0001 at 0012]; Transcript of the Commission, 20 February 2024, T588.10-21 (Vinton); Transcript of the Commission, 21 February 2024, T660.40-661.8, T672.18-673.25 (Chiumento); cf Transcript of the Commission, 22 February 2024, T777.5-13 (Clancy).

[948] See, for example, Transcript of the Commission, 21 February 2024, T672.18-673.25 (Chiumento), T732.47-733.16, T743.45-744.21 (Anderson).

[949] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [12.22] [SCI.0011.0814.0001 at 0121].

[950] Transcript of the Commission, 23 February 2024, T920.22-39 (Rechbauer).

[951] Transcript of the Commission, 23 February 2024, T1010.18-22 (Gendy).

[952] Exhibit B.23.14, NSW Health Procurement Procedures (Goods and Services) (June 2022) pp 61-62 cl 7.6.1 [MOH.0001.0366.0001 at 0061-0062].

to contract management for over 80 per cent of the contracts it managed.[953] The Auditor-General specifically found that "HealthShare's contract management practices are limited by inadequate performance monitoring", noting that HealthShare had advised it did "not have the capacity to closely manage individual contract performance, and even if it did, it does not have the information to do so".[954] The Auditor-General also noted HealthShare's advice that its contract management approach "primarily involves HealthShare contract managers relying on information they receive from contract users and suppliers".[955]

20.97. The Procurement Reform Program was in part a response to the NSW Auditor-General's report to Parliament in October 2019 and was implemented with a view to having a material impact on the contract management issues identified by the Auditor-General.[956] In doing so, one of the actions taken was to implement the new "Operating Model", which included a new framework for contract management that included funding 76 additional full time equivalent (FTE) staff over two years across LHDs, HealthShare, eHealth and NSW Health Pathology to perform contract management.[957] Appropriate levels of resourcing are clearly critical. However, it does not follow that an increase in FTE will result in improved contract management across the system unless there are clear and effective structures and procedures for that to occur.

[953] Exhibit B.23.15, Audit Office of NSW, *Ensuring contract management capability in government – HealthShare NSW* (31 October 2019) p 2 [MOH.0001.0013.0001 at 0006].

[954] Exhibit B.23.15, Audit Office of NSW, *Ensuring contract management capability in government – HealthShare NSW* (31 October 2019) pp 3, 19-21 [MOH.0001.0013.0001 at 0007, 0023-0025].

[955] Exhibit B.23.15, Audit Office of NSW, *Ensuring contract management capability in government – HealthShare NSW* (31 October 2019) pp 3, 19-21 [MOH.0001.0013.0001 at 0007, 0023-0025].

[956] Transcript of the Commission, 23 February 2024, T960.9-961.18 (Rechbauer).

[957] Transcript of the Commission, 23 February 2024, T960.9-961.18 (Rechbauer), T1012.43-1013.4 (Gendy); Exhibit B.5, Statement of Michael Gendy (31 January 2024) [30(a)], [64(a)] [MOH.0001.0434.0001 at 0006, 0021-0022].

Conclusion

20.98. NSW Health has done much to improve its procurement processes in recent times. Those improvements have resulted in significant benefits to the system. However, there is more that can – and should – be done, to embed concepts of value into those processes. Not only with that approach result in enhancements to the procurement process, it is likely to deliver wider system benefits.

> **Recommendation 35:** NSW Health should develop and implement a systematic approach to embedding value based healthcare in its procurement processes, including developing and implementing clear and specific processes for:
>
> a. determining the components of value that are to be pursued in a particular procurement process;
>
> b. evaluating different options for procurement, including tenders, against each of those components of value;
>
> c. formalising and clarifying the role of CEC and the ACI in the procurement function, including by identifying the circumstances when and how those agencies should be involved in procurement activities;
>
> d. consulting as appropriate with clinicians, consumers, community members, suppliers and subject matter experts, in procurement processes.

20.99. I note that in its written submissions NSW Health observed that a recommendation to that effect was consistent with one of the Strategic Procurement Branch's actions identified in the *Future Health Report*.[958] I take that submission to mean that Strategic Procurement Branch will work with HealthShare NSW, eHealth NSW, the ACI, and the CEC to develop and then disseminate principles of value based procurement across the system, and suppliers and industry, in order to promote value based procurement across the system.[959] That is a welcome development that should not only be pursued, but formalised in relevant NSW Health policy.

[958] Exhibit B.5, Statement of Michael Gendy (31 January 2024) [48(h)] [MOH.0001.0434.0001 at 0016].

[959] Submission of NSW Health to the Special Commission of Inquiry into Healthcare Funding (18 February 2025) [12.4] [SCI.0011.0814.0001 at 0115].

Recommendation 36: NSW Health should develop and implement a systematic approach to monitoring the performance of suppliers at a system wide level, including developing and implementing clear and specific processes for:

a. formulating clear and measurable KPIs, including with reference to value based criteria applied in the procurement process;

b. monitoring those KPIs, including designating clear lines of responsibility for performing that monitoring; and

c. obtaining feedback from and providing feedback to local organisations, including users of the relevant goods or services, in a regular and systematic way.