Delivering quality care more efficiently inquiry

Questionnaire response 72

Name: The George Institute for Global Health and The Leeder Centre for Health Policy, Economics and Data

Submission date: 6/06/2025

Participant background

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

   Medical research/health policy institutes evaluating Collaborative Commissioning

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

   Aged care; 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

   The George Institute for Global Health, UNSW Sydney, and The Leeder Centre for Health Policy, Economics and Data (University of Sydney) are currently evaluating NSW Health's Collaborative Commissioning initiative in five regions of NSW in both metropolitan and regional areas: Western Sydney, Northern Sydney, Western NSW (regional) and Murrumbidgee (regional) and South Eastern NSW (regional). The work is funded by an NHMRC Partnerships grant, in partnership with the New South Wales Ministry of Health (NSW Health), LHDs, PHNs, the Consumers Health Forum (CHF) and health service researchers from UNSW's Centre for Big Data Research in Health and the Leeder Centre for Health Policy at the University of Sydney.

About Collaborative Commissioning in NSW

Collaborative Commissioning is a NSW Health initiative aiming to integrate care delivery between the primary and hospital care sectors in NSW, as part of its effort to support value-based care. Like other jurisdictions in Australia and overseas, the NSW health system is facing pressures from rising levels of chronic diseases, an ageing population, expensive medicines and technologies, and rising inequities and out-of-pocket costs for consumers and patients. In response to these health system issues, NSW Health has developed a strategic goal to move the health system away from high-acuity, volume, and activity-based care to a value-based system that focuses on the "quadruple aim."*

Collaborative Commissioning is focused on investing in meso-level organisations, Primary Health Networks (PHNs) and Local Health Districts (LHDs), to improve efficiency and support better patient outcomes through forming alliances across care 'silos'. LHDs and PHNs form regional alliances called 'Patient Centred Collaborative Commissioning Groups' (PCCGs) to co-commission health initiatives based on local context and health needs.

As an evaluation team we worked with local regions to develop a theory of change for each local priority initiative that proceeded to implementation under the PCCG banner. We gained insights into the different ways that local regions diagnosed local priorities, decide on a specific local goal and formulate a joint LHD and PHN response to endemic barriers to better integrated care.
The evaluation of NSW's Collaborative Commissioning initiative is ongoing, and further research findings on outcomes and effectiveness, as well as equity implications, will be available in late 2025. Below we have provided an example of a care pathway delivered as part of Collaborative Commissioning.

Case study of the Northern Sydney PCGG

The Northern Sydney Rapid Care Pathway is a regionally led initiative to reduce avoidable emergency department (ED) presentations among older adults by delivering proactive, coordinated care in the community. It is part of the broader Northern Sydney Patient-Centred Co-Commissioning Group—a partnership between the North Sydney Local Health District (NSLHD) and the Sydney North Health Network (SNHN). The region comprises around 939,000 people, with a rapidly ageing population projected to see an 80% increase in those aged 75+ by 2041. Older people were prioritised for this initiative as they are increasingly presenting to EDs for conditions that could be safely treated in the community.

Pathway Components:
1. GP 'In-Reach': GPs use risk tools to identify patients aged 75+ at risk of hospitalisation. Patients undergo a baseline assessment and receive proactive follow-ups. Practices are supported with care coordinators, local service directories, and incentive payments.
2. GP Outreach: GPs partner with geriatricians to manage complex cases and refer patients to relevant services.
3. Hospital in the Home (HiTH): Enhanced GP access to HiTH services and remote patient monitoring help detect early signs of health deterioration.

4. Rapid Response: Rapid Response teams provide timely care to prevent ED visits for patients experiencing acute or functional decline. Referrals are streamlined through NSW Ambulance.

Extensive stakeholder consultation with providers, consumers, and carers revealed several important insights that informed the care pathway, including that:
• Older people's needs vary widely, requiring flexible, culturally appropriate care.
• Service navigation is complex, with long wait times and limited GP availability.
• Many prefer to see their GP during health crises but often resort to ED due to access issues.
• GPs sometimes use EDs as a gateway to specialist care.

As part of the academic team's evaluation, the pathway will be assessed based on care utilisation, quality, and patient and provider experience, comparing enrolled patients with matched control groups from other Sydney regions, as well as within Northern Sydney. A formative evaluation has also been conducted to examine implementation factors—such as enablers, barriers, and sustainability—using program data, surveys, and interviews with stakeholders.

* The Quadruple Aim: Improved health outcomes for the population, improved cost efficiency of the health system, improved provider and clinician experience, and improved experiences for people, families and carers.

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

Australia has a high-performing health system on most measures, but many patients still have difficulty accessing care and navigating the care process.* Federated health system governance, based on differential responsibilities, and volume-driven funding models, are not conducive to managing long-term, chronic conditions for patients. Activity-Based Funding for Hospitals at the State level, and Fee-for-Service funding models for GPs and primary care providers through Federally funded Medicare, both reward throughput, rather than better health outcomes or prevention.

There have been many attempts at health reform focusing on coordinated care in Australia, including Health Care Homes, the Diabetes Care Project and two rounds of Coordinated Care trials as well as GP Superclinics and the Federal Integrated Care and Commissioning Initiative currently underway. These initiatives have attempted to address the rising rates of chronic, and complex health needs faced by Australians, and the associated rising health care costs.

There are many potential benefits to Collaborative Commissioning. Unlike other attempts at delivering integrated care reforms, Collaborative Commissioning invests at the 'meso-level' of PHNs and LHDs, which presents a 'middle out' approach to reform health care incentives within Australia's system of federated governance. By using a whole-of-system approach, pooling funding and accountability mechanisms for delivering care, Collaborative Commissioning has the potential to provide the integrated care needed to address chronic and complex conditions. Strong patient and community engagement, which is embedded in the approach, means care can be tailored to meet local health needs.

To understand the potential efficacy gains of a Collaborative Commissioning approach,

NSW Health conducted a modelling study of Northern Sydney's rapid care pathway. They built a dynamic simulation model to analyse the sustainability and assess the costs and benefits of a state-wide implementation of the rapid care pathway. Based on the assumption that the pathway would take five years to implement, there was a notable reduction in emergency presentations for the target population, reduction in associated hospital admissions, and reduction in associated ambulance transfers, state-wide.

* Commonwealth Fund 2024, 'Mirror Mirror 2024, A Portrait of the Failing US Health System, accessed 06 June 2025: https://www.commonwealthfund.org/publications/fund-reports/2024/sep/mirror-mirror-2024.

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?

Despite the promising findings from the modelling work, it remains to be seen to what extent Collaborative Commissioning can achieve such outcomes in practice. The impact evaluation conducted by The George Institute, to be finalised late in 2025, will address these questions and inform future policy decisions in NSW with clear relevance to other jurisdictions across Australia. Given the initiative's primary funding source and governance structures, namely NSW Health, the evaluation is expected to focus on outcomes closely aligned with health system priorities at the State-level — particularly those related to hospital activity.

Based on our experience to date evaluating Collaborative Commissioning initiatives across NSW, we have identified three main challenges to effective implementation: 1) robust governance structures to build trust and collaborative relationships at different levels, 2) adequate stimulus funding to get started and then ongoing commitments to sustainable funding, and 3) clear alignment between state level policy and regional level implementation of service delivery models. Based on these challenges, we suggest the following are prioritised as enablers for effective Collaborative Commissioning initiatives:

Building collaborative governance to overcome system silos

Effective Collaborative Commissioning depends on strong, genuinely shared governance and leadership. This extends across multiple layers: between PHNs and LHDs, between payers (a joint commissioning group) and service providers, as well as between regions and the states. The joint planning and accountability required as part of Collaborative Commissioning requires significant shifts in how providers are incentivised to operate. Hospitals and outpatient services are deeply aligned to Activity-Based Funding models and service agreements from the States, while primary care providers rely on fee-for-service models under Medicare as their sustainable source of income. Co-commissioning can act as a neutral and flexible funding source to bridge these ingrained differences — but only if the governance of the commissioning body is designed to balance priorities across hospital (LHDs) and community sectors (PHNs, GPs and private providers). If there is imbalance in the governance, there is a risk that decisions made by the commissioning body will be skewed towards the interests of one part of the health system, undermining the whole-of-system intent.
Lessons from earlier coordinated care initiatives, such as the Health Care Homes trial (2017–2021) reinforce the importance of meaningful provider engagement. The evaluation found that patients enrolled had no measurable changes in clinical risk

factors for chronic disease or hospital use, there was little change in care coordination, and patient experience. This outcome was largely driven by inadequate engagement with providers – by the end of the trial, less than half of providers were still enrolled so there was limited opportunity for impact.

Even where there is strong local commitment to collaboration, structural funding splits — particularly where the funding line remains tied to either Federal or State streams — can gradually erode alignment of priorities. This challenge has been evident in the implementation of NSW Collaborative Commissioning. While the initiative was grounded in the principles of joint planning and shared accountability for outcomes, in practice, key design features reflect a focus on hospital cost savings — highlighting the influence of State-level funding priorities. For Collaborative Commissioning to succeed, governance must be genuinely collaborative, with a balance of influence across stakeholders. In parallel, system planners and funders must ensure the right incentives and supports are in place to help providers transition to new ways of working. Ongoing evaluation will be critical to identify which models most effectively promote trust, alignment, and lasting service transformation.

Investment in infrastructure and workforce to enable integrated care

One of the barriers to effective collaborative care is the inability to share information across health providers, resulting in siloed health responses. Unlike the UK, Europe and South Korea, Australia does not have large scale infrastructure and processes in place for linked data. This prevents health policy makers and providers from understanding how well the health system performs and identifying policy solutions to improve the patient journey and health outcomes. The Leeder Centre, as part of its NHMRC Centre of Research Excellence for Integrated Health and Social Care has reviewed and ranked Australia's national integrated policy supports, including data sharing. The review found that as patient journeys become more complex and service delivery more diverse, gaps and system incompatibilities increase, demonstrating the need for careful policy design and implementation that is culturally responsive and accounts for the needs of diverse stakeholders.

Several jurisdictions in Australia are pursuing data linkage projects to overcome the fragmentation of the patient journey for health service planners. The George Institute has been funded by the Medical Research Future Fund to leverage Lumos, an ethics-approved program that follows patient journeys through the New South Wales health system, to inform multidisciplinary care across the primary and acute care sectors. The project will provide novel insights into patient journeys across the health system and identify and evaluate policy interventions at the national level. The project will also conduct citizens assemblies – to maximise consumer participation – and assemble annual national symposia of government, academia, and civil society to share learnings on the use of linked data for improving multidisciplinary care and to support the National Hub and Spoke Model.

Alongside effective use of data, infrastructure such as integrated health information systems, quality improvement processes, and robust financial and performance monitoring systems are likely to be key drivers of success in Collaborative Commissioning. Based on the case study of North Sydney, sufficient investment in care coordination also appears to be a driver of success. The evaluation of the Coordinated

Care Trials demonstrated that care coordination is inherently complex, and expensive, and success is dependent on effective recruitment, skills-building and training of a coordinated care workforce. Investment in leadership development, as well as training and development support can build capacity in co-commissioning, joint planning and governance amongst workforce across sectors in both PHNs and LHDs.

It is important to note that Collaborative Commissioning should be viewed as an incubator of health system reform, that is part of wider reform initiatives. The PCCGs as part of Collaborative Commissioning are not immune from the challenges faced in the broader health system itself that hamper innovation and patient-centred care. The historical focus of resourcing for public hospitals has made it difficult to rectify fragmentation in health system governance and achieve enduring improvements in patient outcomes. To achieve broader health system reform, a funding shift is needed from more expensive hospital care towards cost-effective care in the community. Multidisciplinary, team-based primary care is difficult to sustain with existing payment models and thus blended payment models which involve a combination of bundled payments, fee for service, and incentives is needed. These broader workforce and health system reforms are needed alongside implementation of Collaborative Commissioning initiatives.

Sustainable financing that supports collaboration across sectors

Collaborative Commissioning initiatives are resource intensive and need reliable, ongoing funding to be effective. An important enabler to effective implementation is sufficient initial investments from the government(s) to support start-up activities between providers and to create the institutional conditions necessary for joint planning. Further, given improved outcomes from Collaborative Commissioning may take time to emerge, funding and governance decisions that take a long-term approach are needed. The modelling study of Northern Sydney showed that while reductions in hospital activity may take a while to accrue, the potential benefits over the longer-term are large, demonstrating the benefits for government, providers and patients of funding that overrides short-term cycles.

Further, sufficient investment from both levels of government (State, and Federal) is needed to ensure true collaboration is realised. If funding for Collaborative Commissioning is predominantly at the State level (LHDs) it does not provide an adequate incentive for primary care integration. As mentioned, reforms to the fee-for-service model within Medicare are needed in parallel to initiatives like Collaborative Commissioning to meaningfully improve patient outcomes and health system efficiency. To enable genuine whole-of-local-system accountability, funding must be freed from existing silos at all levels of the health system, and jointly stewarded through collaborative governance structures.

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

The George Institute and The Leeder Centre joint response to Productivity Commission Inquiry – Pillar 4: Delivering quality care more efficiently

Embed collaborative commissioning to increase the integration of care services

June 2025

What is your experience with collaborative commissioning?

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Co-Commissioning Group—a partnership between the North Sydney Local Health District (NSLHD) and the Sydney North Health Network (SNHN). The region comprises around 939,000 people, with a rapidly ageing population projected to see an 80% increase in those aged 75+ by 2041.

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Pathway Components:

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4. **Rapid Response:** Rapid Response teams provide timely care to prevent ED visits for patients experiencing acute or functional decline. Referrals are streamlined through NSW Ambulance.

Extensive stakeholder consultation with providers, consumers, and carers revealed several important insights that informed the care pathway, including that:

- Older people's needs vary widely, requiring flexible, culturally appropriate care.
- Service navigation is complex, with long wait times and limited GP availability.
- Many prefer to see their GP during health crises but often resort to ED due to access issues.
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Australia has a high-performing health system on most measures, but many patients still have difficulty accessing care and navigating the care process.[i] Federated health system governance, based on differential responsibilities, and volume-driven funding models, are not conducive to managing long-term, chronic conditions for patients. Activity-Based Funding for Hospitals at the State level, and Fee-for-Service funding models for GPs and primary care providers through Federally funded Medicare, both reward throughput, rather than better health outcomes or prevention.

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Initiative currently underway. These initiatives have attempted to address the rising rates of chronic, and complex health needs faced by Australians, and the associated rising health care costs.

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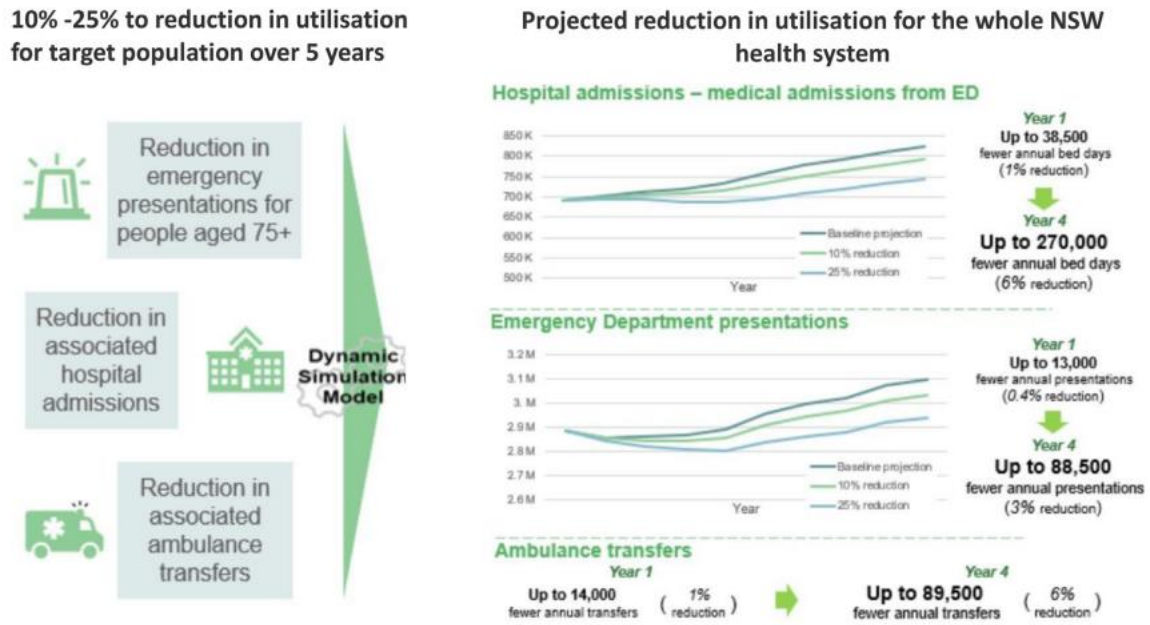

Fig. 3: **Potential activity benefits from a statewide scale-up of the rapid care pathway—findings from a dynamic simulation model.**

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?

Despite the promising findings from the modelling work, it remains to be seen to what extent Collaborative Commissioning can achieve such outcomes in practice. The impact evaluation conducted by The George Institute, to be finalised late in 2025, will address these questions and inform future policy decisions in NSW with clear relevance to other jurisdictions across Australia. Given the initiative's primary funding source and governance structures, namely NSW Health, the evaluation is expected to focus on outcomes closely aligned with health system priorities at the State-level — particularly those related to hospital activity.

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Lessons from earlier coordinated care initiatives, such as the *Health Care Homes trial* (2017–2021),[ii] reinforce the importance of meaningful provider engagement. The evaluation found that patients enrolled had no measurable changes in clinical risk factors for chronic disease or hospital use, there was little change in care coordination, and patient experience. This outcome was largely driven by inadequate engagement with providers – by the end of the trial, less than half of providers were still enrolled so there was limited opportunity for impact.

Even where there is strong local commitment to collaboration, structural funding splits — particularly where the funding line remains tied to either Federal or State streams — can gradually erode alignment of priorities. This challenge has been evident in the implementation of NSW Collaborative Commissioning. While the initiative was grounded in the principles of joint planning and shared accountability for outcomes, in practice, key design features reflect a focus on hospital cost savings — highlighting the influence of State-level funding priorities. For Collaborative Commissioning to succeed, governance must be genuinely collaborative, with a balance of influence across stakeholders. In parallel, system planners and funders must ensure the right incentives and supports are in place to help providers transition to new ways of working. Ongoing evaluation will be critical to identify which models most effectively promote trust, alignment, and lasting service transformation.

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become more complex and service delivery more diverse, gaps and system incompatibilities increase, demonstrating the need for careful policy design and implementation that is culturally responsive and accounts for the needs of diverse stakeholders.

Several jurisdictions in Australia are pursuing data linkage projects to overcome the fragmentation of the patient journey for health service planners. The George Institute has been funded by the Medical Research Future Fund to leverage Lumos, an ethics-approved program that follows patient journeys through the New South Wales health system, to inform multidisciplinary care across the primary and acute care sectors. The project will provide novel insights into patient journeys across the health system and identify and evaluate policy interventions at the national level. The project will also conduct citizens assemblies – to maximise consumer participation – and assemble annual national symposia of government, academia, and civil society to share learnings on the use of linked data for improving multidisciplinary care and to support the National Hub and Spoke Model.[3]

Alongside effective use of data, infrastructure such as integrated health information systems, quality improvement processes, and robust financial and performance monitoring systems are likely to be key drivers of success in Collaborative Commissioning. Based on the case study of North Sydney, sufficient investment in care coordination also appears to be a driver of success. The evaluation of the *Coordinated Care Trials* demonstrated that care coordination is inherently complex, and expensive, and success is dependent on effective recruitment, skills-building and training of a coordinated care workforce.[iv] Investment in leadership development, as well as training and development support can build capacity in co-commissioning, joint planning and governance amongst workforce across sectors in both PHNs and LHDs.

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[3] In October 2023, Australian federal, state and territory Health Ministers and Chief Executives agreed in-principle to designing a National Hub and Spoke Model for sharing health service data. This model will be based on Lumos.

Further, sufficient investment from both levels of government (State, and Federal) is needed to ensure true collaboration is realised. If funding for Collaborative Commissioning is predominantly at the State level (LHDs) it does not provide an adequate incentive for primary care integration. As mentioned, reforms to the fee-for-service model within Medicare are needed in parallel to initiatives like Collaborative Commissioning to meaningfully improve patient outcomes and health system efficiency. To enable genuine whole-of-local-system accountability, funding must be freed from existing silos at all levels of the health system, and jointly stewarded through collaborative governance structures.

References

[i] Commonwealth Fund 2024, 'Mirror Mirror 2024, A Portrait of the Failing US Health System, accessed 06 June 2025: https://www.commonwealthfund.org/publications/fund-reports/2024/sep/mirror-mirror-2024#footnote9.

[ii] : Pearse,J, Mazevska, D, McElduff, P, et.al 2022, *Health Care Homes trial final evaluation report, Volume 2: Main report*, Commissioned by The Department of Health and Aged Care, Canberra.

[iii] Guajardo MGU, Mukumbang FC, Dronavalli M, et.al 2025, 'Innovative Policy Supports for Integration in Health and Social Care Focused on Culturally and Linguistically Diverse Populations in Australia: A Qualitative Study', *J Immigr Minor Health*, Apr 29. doi: 10.1007/s10903-025-01697-8.

[iv] Australian Government Department of Health and Ageing, *The National Evaluation of the Second Round of Coordinated Care Trials, Final Report*, Canberra.