Delivering quality care more efficiently inquiry

Questionnaire response 77

Name: Medical Software Industry Association

Submission date: 8/06/2025

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.

   Aboriginal Community Controlled; Aged care; Disability; Early childhood education and care; Health; Veterans

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?

   To a great extent

2. What are the reasons for your answer?

   Differing levels of comprehension in the health workforce make the varying regulations challenging for part timers who could otherwise mobilise their skills more easily. Less workforce + less access to care.

   Harmonisation of standards through a single National Clinical Safety Framework recognised by all jurisdictions and anchored in ACSQHC or ISO 14971 could improve this. Obviously the federated nature of Australia brings challenges here without a corollary benefit, particularly given the fluidity of the population.

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

   To a great extent

4. What are the reasons for your answer?

   Fundamentally quality and safety are national imperatives. The workforce is mobile. Having various regulations when the same outcome of quality safe patient care is the goal for all, makes no logical sense.

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

1. What is your experience with collaborative commissioning

   Our membership responds to RFTs and collaborative commissioning.
   Make interoperability KPIs—real-time discharge summaries, pathology events, medication-summary completeness—explicit eligibility criteria in pooled-fund pilots.
   Although there is not a detailed report available yet, the recent commissioning by Defence for the shared care record appears to have been effective.

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

   Clearer purpose, less duplication, more transparency.

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?

   lack of harmonised regulations can make it impractical across various governments.

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 responsibility of the Commonwealth Govt for primary health care and the Jurisdiction responsibility for Hospitals mean that there is rarely agreement on funding preventative help in primary care. It is called the blame game and has been called out by The Grattan Institute.

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

   Please see the annexure to this submission being uploaded for a list of some of the preventative work done through health software companies with their clients.

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

   Reward outcomes not transactions via Medicare.

   Consider the legalisation of primary care rebates/preventative health through private health insurance.

   Harmonise regulations for certainty and investment,

   Provide funding for software companies to educate and implement their products to give consumers more autonomy and information so they can observe and measure their health.

Cover sheet: Supporting document #1

2025 Incoming Government Brief for Productivity

48th Parliament of Australia

Powering Australia's healthcare for all Australians wherever they are. #thegoodtech

MSIA
MEDICAL SOFTWARE INDUSTRY ASSOCIATION

Acknowledgment of Country

The Medical Software industry of Australia acknowledges traditional custodians of country throughout Australia and recognises the continuing connection to lands, waters and communities. We pay our respects to Aboriginal and Torres Strait Island cultures and to Elders past and present.

Contents

Congratulations on your second term, working together for healthier, safer and more productive Australia.

The Medical Software Industry Association congratulates the Albanese Government on its re-election. We stand ready to partner with you to lift health, disability and aged care outcomes and national productivity for every Australian.

Why this Briefing matters

Our 140-plus member companies supply the world-class software running public and private healthcare across Australia. They already enable millions of telehealth consultations each year and underpin hundreds of millions of secure clinical transactions — the digital backbone of connected care, Closing the Gap for First Nations Peoples and ensuring equitable access for rural, remote and vulnerable communities.

MSIA has a proven record of constructive co-design with government, from the My Health Record secure-messaging mandate to standards-based e-referrals in aged care. These same frameworks can accelerate reforms across Medicare, the PBS, the NDIS and foundational supports within the expanded Department of Health, Disability and Ageing.

Delivering on the Albanese Government's priorities

Productivity
The Productivity Commission's 2024 Report estimates digital efficiency could save $5 billion a year in public-hospital costs alone — gains our members can unlock for Treasurer Chalmers

Health, Disability & Ageing
MSIA members software hold the digital tools to strengthen Medicare, deliver generational aged-care reform and future-proof the NDIS. Our members can achieve Minister Butler's generational reform.

Aged Care & Seniors
Minister Rae is embracing this challenging portfolio of reform for Australia. Provider and software readiness for the 1 July 2025 aged-care reforms is a shared goal to ensuring no Australian is left behind. Our industry is doing what it takes.

Cyber Security
Our sector secures Australia's most sensitive information and can fast-track implementation of the 2025-30 Cyber Security Strategy. We are working across Department's to achieve Minister Burke's chief objectives which can be realised through collaboration with our industry.

Digital Government and Service Delivery
Whole-of-government platforms that lift productivity and citizen experience depend on seamless MSIA integration. Virtually every MBS and PBS claim is made on our members systems which can be improved for Minister Gallagher through our industry.

This paper sets out the key issues and MSIA recommendations for each portfolio. We would welcome the opportunity to brief you or your senior advisers over the next fortnight.

Emma Hossack
CEO
Medical Software Industry Association

The MSIA supports Australia's health software industry for equitable access to healthcare & productivity.

MSIA Priority Actions:

Cost, Budget Impact, Benefits & Timeline

Action	Indicative Cost to Government	Net Budget Impact	Patient-centred Benefit	Timeline / Milestones
Targeted Interoperability Acceleration Program	Funded via 0.15 % micro-levy on MBS/PBS outlays (~A$95 m p.a.)	Levy-financed (budget-neutral); unlocks Productivity Commission-modelled $5 bn p.a. hospital efficiency dividend	Real-time data at point-of-care; fewer duplicate tests/faxes; lower medication-error risk	Levy enacted 2025-26 Budget; vendor certification aligned to 1 Jul 2025 aged-care & Cyber Strategy milestones
Fair-Go Procurement Renewal	≈A$1 m one-off White Paper; credit-guarantee fee-funded (cost-neutral)	Lower tender prices; wider bidder pool; risk underwritten without cash outlay	Faster access to innovative local tools; more choice for rural & aged-care services	White Paper Q1 FY 25-26; SourceIT-Lite & guarantee pilot live 1 Jul 2026
Implementation & Training Partnership Fund	Pilot envelope A$21.225 m (Apr 2025-Jun 2026)	Prevents failed roll-outs; earlier reform benefits	Rapid, consistent uptake of mandated features; clinicians trained by software vendors	Fund opens Jul 2025; vouchers acquitted within 12 months of go-live
OPA Connect Gateway for Online Prescription Authorities	One-off build < A$10 m plus integration grants (from DOP pool)	Removes > 4 m GP calls; billions in PBS workflow savings	30-second digital approvals; faster dispensing; safer aged-care prescribing	Gateway live within 12 months; 98 % authority items digital by Q4 FY 25-26
National Data-Governance Unification	< A$5 m to consolidate frameworks & sandbox	Cuts SME compliance spend; faster procurements	Consistent privacy & security boost patient trust; quicker tool roll-out	Framework legislated FY 25-26; GovData-Ready certificate by 2026
Digital Outcomes Payment (re-cast ePIP)	Re-allocates existing ePIP pool (no new spend)	Redirects funds to proven outcomes; stops leakage	Clinician time freed; automated reporting; aligns with OPA/FHIR mandates	Blueprint mid-2025; first metrics funded 1 Jul 2026
Efficiency-First Conformance Package	Sandbox & voucher scheme scoped with Interoperability Fund (moderate)	Avoids duplicate testing; lowers regulatory cost	Faster access to safe AI & SaMD; SMEs stay in market	Sandbox live Q2 FY 25-26; mutual-recognition regime fully adopted 2027

Priorities for a smarter, safer, more productive Australian health system.

Powered by digital innovation that improves patient outcomes, empowers clinicians, and secures national data.

Facilitate the Speed of Health Interoperability

Through resourcing health software companies to educate and implement their solutions which would dramatically increase productivity.

Procurement Reform

Creating a fair, SME-friendly, IP-smart and competitively-neutral market.

Implementation & Training Support

Funding the change-management “last mile” after every digital-health reform.

AI Regulation

Toward a principles-based, risk-proportionate and SME-friendly framework.

Conformance Versus Efficiency

Ensuring regulation is proportionate, risk-based and innovation-friendly.

Online Prescription Authorities (OPA)

Turning a $19 billion process from “partly effective” to seamless, data-rich and doctor-friendly.

Health-Software Accelerators

From “scatter-gun” funding to a focused, challenge-driven pipeline for innovation at scale.

Data Governance

Moving from many overlapping frameworks to one clear, risk-based system.

Medicare Digital Incentives

Advance from activity-based payments to outcome-driven, vendor-enabled reform.

Facilitate the Speed of Health Interoperability

Through resourcing health software companies to educate and implement their solutions which would dramatically increase productivity.

Every month up to 7 million patient results fail to flow between clinics because legacy systems still can't talk FHIR—costing Australia $420 million in repeat tests and preventable admissions. Many clinical systems struggle to exchange data seamlessly because vendors lack the bandwidth – people, cash and sand-boxed test environments – to fast-track implementation of evolving national standards (FHIR-based APIs, secure-messaging, e-referrals, e-prescribing). Delays keep duplicative manual workflows in place, create safety risks when information is missing at the point of care, and slow progress on priority reforms across Medicare, PBS, NDIS and aged care. The 2020 ANAO audit response confirms that higher-assurance, ISM-aligned security controls must now also be built into all connecting software, adding further effort for already-stretched vendors.

This slows the progress across Medicare, PBS, NDIS and aged care – costing the Budget millions the Treasurer can allocate to savings.

SOLUTION
Establish a Targeted Interoperability Acceleration Program

Directly funds vendor implementation. Competitive grants or outcome-based vouchers for software companies to build, test and deploy priority interoperability use-cases (e.g., event summary, discharge summary, e-referral) and the security controls mandated in the ANAO assurance framework.

Provides national sandboxes & conformance labs. Cloud test beds, reference APIs and automated test suites run by ADHA/MSIA so every vendor can prove compliance once and connect everywhere.

Delivers practical workforce training. Subsidised micro-credentials and vendor-to-vendor "code camps" so SMEs and large vendors alike can skill up quickly on FHIR, SNOMED CT, OWASP-aligned secure coding and ISM Essential Eight practices.

Aligns incentives & deadlines. Tie program milestones to upcoming policy drivers (e.g., 1 July 2025 aged-care reforms, Cyber Security Strategy 2025-30) and make certification a pre-requisite for claiming modernised MBS/PBS items.

Include a $20 Million Interoperability Acceleration Fund in the October 2025 Budget.

BENEFITS

Productivity dividend. Removes duplicate data entry and faxes, cuts $5 billion annually in hospital waste, per Productivity Commission (2024). Practices that adopt SmartForm e-referrals typically cut fax usage by 70–90 per cent within the first quarter, according to PHN rollout data.

Better, safer care. Clinicians gain real-time, complete patient data, reducing medication misadventures and supporting continuity of care for First Nations, rural and vulnerable Australians.

Cyber-resilience by design. Embeds ISM-mapped security controls across the vendor ecosystem, reducing breach risk and supporting the 2025-30 Cyber Security Strategy.

Economic growth. Accelerates time-to-market for Australian health-tech, boosting exports and high-skill jobs while attracting private investment into the sector.

Government reform enabler. Provides the digital plumbing that Ministers Butler, Rae, Chalmers, Gallagher and Burke need to deliver generational change in Medicare, aged-care, NDIS, cyber security and whole-of-government service delivery.

Procurement Reform

Creating a fair, SME-friendly, IP-smart and competitively-neutral market.

Capital-barrier "glass ceiling." Many RFTs insist on multi-million-dollar turnover tests or unlimited parent guarantees, benchmarks few Australian digital-health SMEs can meet. SME's make up 97% of Australian businesses but win only 11% of procurement value. MSIA's 2025-26 Budget submission calls this the key barrier and proposes that government underwriting "level the playing field" so innovators can bid with confidence.

Competitive-neutrality breaches. PHNs have used Commonwealth grants to build and distribute software such as Primary Sense and HealthPathways, directly competing with commercial vendors despite the Commonwealth Competitive Neutrality Policy Statement's requirement that publicly funded entities not distort markets. Complex, inconsistent rules. More than 120 entities overlay bespoke conditions on the Commonwealth Procurement Rules (CPRs); the July 2024 update lifted SME targets to 25 % (< A$1 bn) and 40 % (< A$20 m) and raised the direct-buy threshold to A$500k, yet compliance and transparency remain patchy.

Paperwork & legacy IP clauses. SourceIT-Plus contracts still run past 100 pages and vest all foreground IP in the Crown, ignoring the Attorney-General's 2012 IP Manual that advises licence-back, not acquisition.

Insurance. The current insurance requirements for contracts in public and state RFTs are often not fit for purpose requiring cover in excess of the value of the contract and not matched to the risk. This disincentivises smaller innovative companies which lack the bargaining power with insurers.

Transparency of Procurement success. The ANAO reports on large procurements e.g. Defence ands MyHR. Trust, accountability and improvements to process are necessary to drive return on investment are all procurements were flagged for annual updates on how they are meeting objectives or not.

SOLUTION
Fair-Go Health-ICT Procurement Renewal Package

Commonwealth SME Credit-Guarantee Facility.

- Treasury, Export Finance Australia and MSIA co-design a pilot guarantee that tops up performance bonds or provides partial contract-value guarantees for qualifying Australian vendors.
- Fund an initial **White Paper (2025-26 Budget Submission to include this measure in Budget Paper No.2 under treasury/ Finance)** to scope parameters, risk pricing and governance.
- Limit individual exposures (e.g., A$5 m) and charge a modest fee so the scheme is fiscally neutral over time.

Unified rules & 20-page "SourceIT-Lite".

- Finance publishes a live register of CPR deviations and issues a plain-English modular contract that:
  – defaults IP ownership to the supplier with a perpetual, royalty-free government licence;
  – caps liability at proportionate fault;
  – embeds outcome-based milestones.
- Any true IP assignment must be CIO-approved and logged on AusTender with a short justification tag.

SME-First pathways.

- Default to CPR **Exemption 17** for procurements < A$500 k; mandate an SME weighting in the "broader economic benefit" assessment for contracts > A$1 m and publish progress towards the 25 %/40 % targets.

Always-open digital-health panel + "try-before-buy". Quarterly refresh; require at least one SME on every shortlist and allow A$200 k rapid proofs-of-concept using the Commonwealth Contracting Suite.

Accredited "IP-Smart Buyer" program. MSIA/Finance micro-credential covering FHIR, cyber-risk, agile contracting and the 2012 IP Manual; graduates flagged on AusTender.

Competitive Neutrality Enforcement Stream.

- Mandatory CN test for any entity (PHNs, hospitals, agencies) proposing new software development; they must publish evidence that no suitable commercial alternative exists.
- Empower the Productivity Commission's Competitive Neutrality Complaints Office to initiate investigations, issue binding directions and levy penalties within 90 days.

Live performance dashboards. AusTender displays cycle-time, SME share, IP-ownership status, CN compliance and delivery outcomes—driving continuous improvement.

Transparency of Procurement process and Value. Drive trust accountability and process uplift by annual l publication of status of procurement, variations, ROI and timelines.

BENEFITS

Level playing field & sovereign capability. Government underwriting plus slimmer templates let Australian SMEs go head-to-head with multinationals, keeping more of the A$70 bn federal spend in local IP and high-skill jobs.

More innovation at lower cost. Wider bidder pools, "try-before-buy" pilots and outcome-based contracts sharpen price tension and speed delivery of cutting-edge digital-health tools.

Reduced project risk. Credit guarantees tackle solvency hurdles without forcing SMEs into risky unlimited indemnities; balanced IP/ licence clauses ensure products can evolve post-implementation.

Market integrity. Enforcing competitive neutrality stops publicly funded bodies crowding out private R&D and focuses PHNs on their commissioning mandate rather than product development.

Transparency & trust. Public dashboards and empowered CN oversight show taxpayers that government buying is fair, efficient and aligned with the Buy Australian Plan and "Future Made in Australia" agenda.

Implementation & Training Support

Funding the change-management "last mile" after every digital-health reform.

Australia repeatedly mandates new digital-health functions (e.g., aged-care star-ratings, e-prescribing updates) yet **offers no dedicated funding to roll them out in clinics, hospitals or pharmacies.** Vendors shoulder the R&D cost, then must also bankroll site-by-site implementation, change-management and staff training — often > 20 % of the original development bill.

When money is available, it is paid to **generic consulting firms with limited product knowledge** or direct to providers, producing slow uptake and fragmented help-desk support.

The result is delayed policy impact, inconsistent cyber-security posture and reform fatigue among clinicians.

SOLUTION
Implementation & Training Partnership Fund

Dedicated funding stream. Establish a competitive grants program tied to each major policy change (e.g., eNRMC, aged-care digital reforms). Vendors apply for **per-site or per-user "implementation vouchers"** that cover training, data migration, workflow redesign and first-line support.

Pay-on-adoption model. Grants are acquitted only when the vendor demonstrates the site is live and clinicians are using the new functionality — aligning spend with real outcomes.

Vendor-led training mandate. Funding flows to the companies that built and already support the software, not to third-party consultants or the end user, ensuring content accuracy and trusted relationships.

Cyber uplift baked-in. Each voucher includes a checklist of Essential-Eight controls; implementation funding can be used for patching, identity management and staff phishing drills alongside functional training.

BENEFITS

Faster, cleaner rollouts. Policy reforms land in months, not years, because the people who wrote the code also manage the go live.

Lower total cost & higher ROI. Government pays once, directly linked to successful adoption, avoiding the "consultants first, fix later" cycle highlighted in previous national programs.

Stronger cyber posture. Embedding security tasks in every funded implementation lifts baseline protection across thousands of small providers.

Clinician trust & efficiency. Training by familiar vendor teams boosts uptake, reduces helpline calls and frees clinicians to focus on care.

Stimulated local innovation. Reliable post-reform funding signals to Australian SMEs that their investment in new features will be supported, sustaining a vibrant home-grown digital-health ecosystem.

AI Regulation

Toward a principles-based, risk-proportionate and SME-friendly framework.

Regulatory sprawl & confusion. Three parallel consultations (Health, DISR, TGA) show the same pain-point: overlapping laws and talk of a brand-new AI Act risk duplicating what already works and slow clinical adoption.

One-size-fits-all guardrails could over-shoot. Mandating every proposed control on every model would burden low-risk uses (scribes, workflow bots) and create a consultancy "tick-box" market, while still leaving gaps for genuinely high-risk diagnostic AI.

SME cost squeeze. Testing, accreditation and documentation land hardest on Australian innovators; without help they may exit or never enter the market.

Fragmented trust signals. Clinicians and consumers lack a simple way to see whether an AI tool is regulated, exempt or proven safe, eroding confidence.

Australian innovation and productivity. Australia's workforce deserves world-class tools to improve their job satisfaction and output. Lack of knowledge breeds fear doubt and uncertainty impeding uptake of useful safe AI solutions.Industry also needs assurance that our regulation is consistent where appropriate and possible with international markets or investment will dry up.

SOLUTION
Calibrated AI Guardrail Package

Adopt "Option 2" across portfolios. Keep TGA software-as-medical-device rules, privacy law and safety standards, but add a short, technology-agnostic AI Principles Act that tells each existing regulator what to clarify — not a brand-new mega-regulator.

Tiered guardrails & sandboxes. Map the ten proposed controls to risk classes; fund national sandboxes/ conformance labs so vendors can self-test once, prove once, and publish the results.

SME Support Fund. Provide vouchers covering up to 80 % of first-time conformance, safety studies and post-market monitoring for Australian SMEs, paralleling the underwriting model proposed for procurement.

Trusted-AI "mark" & open register. A single public database (and symbol for labels/UI) shows whether a tool is: regulated (ARTG number), exempt but conformant to principles, or pending assessment.

Continuous education loop. Resource TGA, ADHA and peak bodies (MSIA, AAAiH) to co-publish plain-English explainer sheets, podcasts and CPD modules, keeping pace with fast-moving models. Ensure workforces are properly resourced for this revolution.

Global harmonisation default. Align definitions and evidence thresholds with IMDRF, ISO 42001 and FDA practice; any Australian divergence requires a regulatory-impact statement up front.

National Trust to pass the "Pub Test". Leverage and support resourcing of the University of Melbourne Law School Centre for AI and Digital Ethics which socialises ideas, canvases opinions and technical and ethical approaches to address public distrust of new technologies.

BENEFITS

Safe innovation. High-risk diagnostic AI stays under tight, updated SaMD rules, while low-risk productivity tools face proportionate checks — reducing both patient harm and red tape.

Faster market entry & lower costs. One sandbox, one badge and targeted vouchers cut compliance time for SMEs, keeping Australian IP onshore and competitive.

Clinician & consumer trust. A visible Trusted-AI mark plus open registry makes it obvious which tools meet the rules, boosting uptake and informed choice.

Regulator efficiency. Clarifying roles lets TGA focus on health-specific evidence, OAIC on privacy and DISR on cross-sector AI principles, avoiding duplicated audits.

International credibility. A harmonised, principles-first system attracts global investment and ensures Australian patients access world-class AI solutions first.

Conformance Versus Efficiency

Ensuring regulation is proportionate, risk-based and innovation-friendly.

"Gold-plated" compliance creep. Agencies routinely mandate UI details, exhaustive documentation or advanced interoperability that add little safety value but absorb upwards of **30–40% of staff time** in some Australian health-software companies. Conformance profiles must be used to address risks but not product design which the marketplace is best suited to address.

Unfunded mandates. Governments require new features or standards yet provide no implementation funding, forcing SMEs either to cross-subsidise public policy or exit the market.

Ambiguous, drawn-out approval pathways. Vague guidance and repeated design reviews delay launches; EU MDR and recent TGA reclassifications have already driven smaller developers from those markets.

Productivity drag & reduced competition. Excessive conformance tasks shrink R&D budgets, slow product cycles and thin the vendor pool, ultimately dampening innovation and raising costs for providers and patients.

SOLUTION
Efficiency-First Conformance Package

Risk-proportionate tiers. Calibrate evidence and documentation to true patient- or user-risk; low-risk tools can self-declare to a core checklist, while high-risk AI/diagnostic software stays under full SaMD rules. Similar risk-based approaches should be deployed for all digital health software verticals including ePrescribing and MyHR connectivity.

Regulatory sandboxes & "test-once, accept-many". Fund national sandboxes where vendors prove security, privacy and interoperability once; results are mutually recognised by TGA, ADHA and state regulators. Testing should be nuanced so it is not required for full features previously tested, but only newly developed discrete features.

Implementation vouchers. Mirror MSIA's training-support proposal: per-site funding that vendors redeem only when new functions are live, covering change-management and cyber-uplift costs.

Streamlined documentation & harmonisation. Adopt common templates, accept international evidence (e.g. IMDRF, ISO 42001) where available and appropriate, and retire duplicative national forms; publish decision timelines to cut re-work.

SME impact test. Any new conformance requirement above a cost threshold must include a Productivity Commission analysis and offsetting funding if compliance costs fall disproportionately on SMEs.

BENEFITS

Faster innovation cycles. Risk-based tiers and test-once sandboxes cut months of re-engineering and paperwork, getting safe tools to clinicians sooner.

Stronger competition & sovereign capability. SMEs stay in the market instead of exiting under compliance pressure, keeping Australian IP and jobs onshore.

Lower whole-of-life cost & higher ROI. Government funds only successful rollouts; providers avoid duplicate consultant spend and gain productivity sooner.

Regulator efficiency & trust. Clear tiers, shared evidence and published timelines focus regulators on true high-risk areas, increasing transparency and confidence among clinicians and consumers.

Online Prescription Authorities (OPA)

Turning a $19 billion process from "partly effective" to seamless, data-rich and doctor-friendly.

$19.5 billion PBS workflow still phone bound. Nearly 7 million "authority-required" prescriptions a year (≈30 % of all PBS lines) still need doctors to phone Services Australia — 54.5 % of requests in 2023-24 — because only one clinical system has built the complex web-service interface.

Prescriber productivity drain. RACGP polls show 75 % of GPs spend 3-10 minutes per call, often while frail aged-care residents wait.

ANAO (Jan 2025) rates PBS administration "partly effective". It flagged OPA as the key bottleneck; Services Australia rejected the recommendation to report against its own 30-second online-approval target.

Services Australia have not adopted the FHIR standards supported by the Department of Health, Disabilities and Ageing interoperability strategy.

SOLUTION
OPA Connect implementation package

Fund & stand-up OPA Connect, a single, vendor-neutral gateway that converts the existing Services Australia web services into a light-touch REST/FHIR* style API. Vendors pass core prescription data, OPA Connect handles all authority questions and returns the approval number.

Stage 1 roll-out (covers > 98 % of authority items) within 12 months; later stages add chemotherapy, complex CAR items, RPBS, etc.

Competitive grant vouchers for software companies to integrate the new API and update customers; pay on proof of live use to align spend with outcomes.

Tight ANAO-aligned KPIs: 30-second median response-time, public dashboard, and inclusion in Services Australia's Annual Performance Statement — fixing the sole ANAO recommendation they declined.

BENEFITS

Billions in system savings. Eliminating 4 + million annual call-centre interactions and duplicated data entry slashes labour costs across prescribers, Services Australia and aged-care facilities.

Doctor time back to patients. RACGP's 3-10 minutes per approval returns to consultations, improving care quality and access.

Faster, safer dispensing. Instant authority numbers reduce prescription errors and delays in starting critical therapies.

Rich, real-time data. Digital submissions feed analytics for PBS utilisation, inappropriate prescribing flags and fraud detection.

Regulatory credibility restored. Measurable, public KPIs move PBS administration from "partly" to fully effective and align with the Productivity Commission's digital-health efficiency agenda.

Health-Software Accelerators

From "scatter-gun" funding to a focused, challenge-driven pipeline for innovation at scale.

Fragmented public investment. Canberra and the states now fund at least six separate health-tech accelerators (e.g., ANDHealth+, MTPConnect's TTRA, state hubs) through the MRFF and jurisdictional grants. Each runs its own intake, mentors and admin team, spreading scarce dollars thinly and duplicating overheads.

Mismatch with market traction. Much of the money targets very early "blue-sky" concepts; fewer resources flow to companies that already have clinically validated products and just need scale support. MSIA's 2025-26 Pre-Budget submission notes that many smaller, lightly connected hubs "have less ability to deliver Government policy and reform" than industry-wide bodies with an established customer footprint.

Weak accountability for return on investment (ROI). Current grants often stop at project completion, with limited visibility of downstream adoption, jobs created or export sales.

SOLUTION
Challenge-Based Accelerator Consolidation Package

Define national "missions". Each Budget cycle, the Department of Health & Aged Care publishes 3-4 priority challenges (e.g., digitally enabled aged-care reform, AI-driven chronic-disease management).

Competitive, winner-takes-most funding. Instead of seeding many hubs, allocate a single, milestone-based grant to one or two lead organisations (accelerators, peak bodies or consortiums) that:

- already support a portfolio with proven clinical use and paying customers; and
- commit co-investment from industry and states.

90 : 10 split between "traction" and "blue-sky". At least 90 % of program funds go to companies that can demonstrate early revenues/clinical adoption; up to 10 % supports horizon-three ideas.

Hard ROI and health-impact KPIs. Lead accelerators must report quarterly on jobs, private capital attracted, export sales, patients reached and clinician productivity gains. Funding tranches are released only on KPI achievement.

Independent productivity audit. The Productivity Commission reviews outcomes two years post-grant and can recommend clawbacks or bonus pools to reward exceptional performance.

BENEFITS

Higher productivity, faster. Concentrating dollars on solutions already gaining traction shortens the path from lab to clinic, freeing clinicians from manual work and lifting system efficiency. Industry investment will grow.

Better health outcomes. Proven tools scale nationally sooner, improving care quality, access and safety across metropolitan and regional settings.

Stronger sovereign industry. Milestone-tied grants leverage private co-investment and export growth, amplifying every taxpayer dollar and anchoring high-skill jobs in Australia.

Reduced administrative overhead. Fewer, larger programs cut duplicated back-office costs and let public servants focus on strategic oversight or working in privately funded organisations, instead of micro-managing many small grants.

Transparent value for money. Public KPI dashboards and independent PC audits demonstrate clear ROI, boosting public trust in innovation funding.

Data Governance

Moving from many overlapping frameworks to one clear, risk-based system.

Fragmented rules cause cost and confusion. Each tier of the health system has its own framework: the Australian Digital Health Agency's corporate "Data & Information Governance" model Digital Health Australia; the RACGP's practice-level security handbook RACGP; state and Commonwealth health departments' frameworks Health and Aged Care Australia; plus the Finance-led whole-of-government framework now under development Department of Finance. Vendors must map to—and insure against—several sets of principles, inflating procurement paperwork and premium costs and slowing adoption of new software.

SOLUTION
National Data-Governance Unification Package

Single over-arching framework. Finish Finance's APS-wide Data Governance Framework and legislate it as the baseline; all sector-specific guides (health, GP, AIHW) become "implementation handbooks" that can add nuance but **may not contradict** the core controls.

National Data Governance Council. Co-chaired by Finance and Health with ADHA, AIHW, OAIC, Peak industry and professional representatives and state CDOs to maintain the common core, approve sector add-ons and publish a living glossary.

One certification, many uses. Create a single "GovData-Ready" conformance assessment (built on the Five Safes, ISO 27001 and the FAIR principles); agencies accept it in lieu of bespoke questionnaires.

Harmonised contract clauses. Insert identical data-governance wording into SourceIT-Lite and state purchasing templates so suppliers don't renegotiate terms agency-by-agency.

Public guidance & sandbox. Fund the University of Melbourne Validitron -run sandbox where vendors can test once against security, privacy and interoperability requirements and publish their pass result in an open registry aligned with the Data & Digital Government Strategy's "Mission 5 – Data Foundations.

BENEFITS

Lower compliance costs. One audit instead of four+ saves SMEs tens of thousands in assessment and insurance fees, freeing capital for R-&-D.

Faster procurement & uptake. Purchasers can rely on the common certificate, cutting tender cycle-time and accelerating clinician access to new tools.

Improved data quality & transparency. A harmonised standard lets AIHW aggregate national datasets more quickly and publish clearer insights for funding and policy.

Greater investor confidence. Clear, stable rules de-risk scale-up capital, boosting domestic innovation and export potential.

Stronger public trust. Consistent privacy and security settings across jurisdictions make it easier to explain protections to patients and clinicians, supporting wider data sharing and AI adoption.

Medicare Digital Incentives

From activity-based payments to outcome-driven, vendor-enabled reform.

Inputs, not outcomes. Medicare's fee-for-service streams and the eHealth Practice Incentive Payment (ePIP) pay clinicians for having capability (e.g., a secure-messaging certificate) rather than proving it is used for safer, faster care. The 2022 Strengthening Medicare Taskforce called for blended, performance-linked funding.

Low digital yield. ANAO's 2024–25 audit found PBS administration only "partly effective"; 29 % of authority scripts still need phone calls, draining 3-10 min per GP per approval.

Provider grants bypass builders. Aged-care "digital-uplift" grants ($10 k per provider) left software companies unfunded for the change-management that decides success—risk flagged in MSIA's March 2025 submission.

Clinician burden & resistance. RACGP and AMA say ePIP rules are paperwork-heavy; AMA warned that "meaningful-use" quotas punish GPs for infrastructure they don't control.

In short, tying incentives to measurable digital outcomes and paying the people who actually write the code and educate the users during implementation turns Medicare's transaction spend into a lever for safer care, clinician productivity and a stronger Australian health-software industry.

Fragmented overseas evidence. Nations that pay vendors for outcomes—e.g., the UK catalogue—report quicker interoperability gains and lower practice overheads.

SOLUTION
Outcome-based Digital Enablement Package

Re-cast ePIP → "Digital Outcomes Payment (DOP)". 70 % of the pool is released only when software auto-reports agreed metrics (e.g., percentage of scripts sent via online authority, secure-message volumes, data-quality score). Part of the funding to be directed to industry to deploy the software services

Vendor-direct vouchers. Practices nominate their accredited software; a Medicare Digital Voucher is paid to the vendor once the outcome metric is met. First three mandates: online prescription authority (OPA Connect), FHIR event summaries, aged-care Support-at-Home claiming.

Shared national APIs & sandbox. Services Australia/ ADHA host open FHIR and security test beds; "test once, accept many" mirrors the UK NHS GP IT Futures model that funds suppliers directly via a buying catalogue.

Public dashboards & claw-back. Quarterly adoption and uptime statistics for each vendor; suppliers that miss service levels lose voucher eligibility, redirecting funds to high performers.

Fund with a micro-levy. Hypothecate 0.15 % of MBS/ PBS outlays (~A $95 m/yr) to sustain vouchers without new Budget spending.

BENEFITS

Faster national rollouts. One conformance tick suffices for every player, slashing vendor re-work and getting new features into clinics sooner.

Transparent accountability. Live data links every public dollar to digital performance, addressing ANAO's oversight concerns and boosting public trust.

Sovereign tech lift. Predictable, milestone-tied revenue lets Australian vendors scale and export—echoing the innovation surge seen under GP IT Futures.

Conclusion

Australia's 140-plus MSIA companies already run the nation's digital pulse. They run the large majority of all hospital EMRs, GP and specialist platforms, aged-care and disability systems, radiology and pathology PACS/RIS, pharmacy dispensing, telehealth and the secure-messaging rails that move almost every Medicare and PBS claim. Our members export world-class code, yet billions in productivity, safety and cyber-resilience gains remain locked behind sprawling procurement red tape, overlapping data rules, unfunded mandates and a call-centre era prescription-authority process that still steals minutes from every consultation.

The incoming Government can release this value by super-charging interoperability through vendor acceleration grants, national FHIR sandboxes and ISM-aligned certification; replacing hundred-page contracts with a 20-page SourceIT-Lite while underwriting SME bids and enforcing competitive neutrality. Initiatives including directing funding to industry when mandated features are live and clinicians trained; installing risk-proportionate AI guard-rails; adopting "test-once, accept-many" conformance sandboxes with an SME-impact lens; converting phone-bound prescription authorities to a single secure API; consolidating scatter-gun accelerator funding into mission-driven programs that back solutions with proven uptake; unifying data-governance into one national certificate; and shifting ePIP from input grants to outcome payments.

The MSIA looks forward to realising the benefits of these initiatives to achieve the Governments vision now.

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The Medical Software Industry Association of Australia (MSIA) powers healthcare in Australia.

We welcome this opportunity to provide a submission to the Department for consideration in the framing of its Budget.

MSIA members enable MBS and PBS, and vital systems including GP and Specialist systems, Pharmacy systems, ePrescribing infrastructure, Hospital systems, Pathology, Radiology, Telehealth/virtual care, Aged Care, Indigenous care, Palliative Care. bookings and payment platforms as well as Australia's Bowel and Breast screening Registers. The Australian Immunisation register and MyHR need information from our members systems to function.

Our members systems make equity of access a reality or possibility for all Australians. Our members make the efficiency and productivity of healthcare possible, but there is much more that could be done today.

The MSIA exists to enable this market to thrive and facilitate more effective and efficient healthcare. In line with the 2025-2026 Federal Budget, this submission highlights key funding priorities essential to supporting the continued growth of the medical software industry and improving healthcare outcomes across Australia.

Our success in these areas is detailed in our

2024 MSIA Annual Report

Cover sheet: Supporting document #2

Submission to the Productivity Commission

Pillars 1, 3 & 4

MSIA
MEDICAL SOFTWARE INDUSTRY ASSOCIATION

Date: 8 June 2025

Acknowledgment of Country

The Medical Software industry of Australia acknowledges traditional custodians of country throughout Australia and recognises the continuing connection to lands, waters and communities. We pay our respects to Aboriginal and Torres Strait Island cultures and to Elders past and present.

The MSIA supports Australia's health software industry for equitable access to healthcare & productivity.

About MSIA Members combined workforce, exports and capability.

MSIA is Australia's peak body for digital-health software, analytics and cloud vendors, representing more than 140 member companies. These companies design, build, maintain and implement the digital foundations of our health system—electronic medical records, prescribing and dispensing platforms, imaging and pathology interfaces, aged-care resident systems, virtual-care hubs and advanced analytics. Collectively our members employ well over 25,000 Australians, export to 40+ countries[1] and process over 95% of Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) transactions daily.

Productivity is at the heart of our purpose: each line of code our members deploy aims to eliminate waste and rework, maximise clinical interactions and reduce processing burdens for administrative staff and clinicians. This enables more focused time with patients and less workers burn out to enable more time with patients. The evidence in this response to the Productivity Commission demonstrates just some of the concrete returns.[2]

We therefore welcome the Productivity Commission's five-pillar agenda and respond specifically to Pillars 1; 3 and 4 where digital health can move the national needle the fastest. We ask Government to grasp three over-arching levers: proportional regulation, outcome-based funding, and system-wide interoperability.

[1] Conservative total derived from large employers plus SME cohort: Sonic Healthcare careers page (accessed 8 Jun 2025) – ">10 000 people nationally". Telstra Health Benefits Brochure 2023, p. 1 – "1,500+ employees, 15 locations". InterSystems "About Us" page – 2 000 global staff; Sydney is APAC dev hub (~250). Dedalus "Global Footprint" – 8 000 staff, including Australian engineering centre. 100+ SMEs averaging 25 staff ≈ 2 500 (10–50 range). Total >25 000.Telstra Health Benefits Brochure 2023, p. 1. InterSystems global footprint (80+ countries) and Dedalus (40); plus, member export case-studies.

[2] The MSIA will have a complete list following the Interim Report.

Creating a Dynamic & Resilient Economy

Digital health is dominated by small-to-medium Australian innovators who carry a disproportionately high compliance and procurement burden. Under the current monolithic accreditation pathways, a start-up clinical decision-support vendor faces the same evidentiary demands as a multi-national cloud host. The result is capital drag and negative impact to innovation and competition.

1. What areas of regulation do you see as enhancing business dynamism and resilience? What are the reasons for your answer?

Tiered accreditation models that calibrate the risk- to benefit.

1. The work by the Department of Health, Ageing and Disabilities provides the possibility of fit for purpose regulation. It is being developed with input from industry and end users in a genuine co-design. The net effect will be reduced procurement red tape and cost to government and industry. It will also increase certainty and confidence for users of health systems.

2. The current Software as a Medical Device (SaMD) regulatory scheme by the TGA provides a harmonized framework which assists in the reduction of red tape by industry exporting overseas because of the Therapeutic Goods Administration (TGA) involvement with the International Medical Device Reform Forum (IMDRF). It also maps to the 11 proposed mandatory Guardrails proposed by the Department of Industry Science and Resources. Risk-based regulation which is supplemented by Essential Principles is an excellent example regulation providing appropriate safety and security without stifling business sustainability and innovation.

2. How has your regulatory burden changed over time?

The MSIA is currently finalising a member survey which demonstrates that the requirements for industry have grown from approximately 20% of resources being allocated to government compliance to 80%. The survey will be available following release of the PC interim report.

3. What regulations do you find time-consuming, overly complex or otherwise constraining business dynamism and resilience? What are the reasons for your answer?

There are three good examples.

1. **Privacy and Security Regulation** - Currently multiple and various security and privacy regulations from Commonwealth and Jurisdictions mean that companies are compelled to conform to varying standards which could be harmonised for a better result for industry, health care providers and consumers. Procurement would be improved and KPMG modelling for the Australian Digital Health Agency (2023) found that every month shaved from procurement lead-time in clinical software equates to AU$50 million in earlier benefits. A risk-tiered accreditation process alone is expected to remove four to six months from 70 % of first-time deployments, implying a net present value of AU$1.2 billion over ten years.

2. **Schedule 8 Medications** - Similarly each Jurisdiction has its own Schedule 8 drug list which means companies must code for safety in several different ways which is illogical, inconsistent and inefficient.

3. **Online Prescription Authorities** - Finally, the regulation of Online Prescription Authorities which account for over $5B of PBS medications per annum have been found to be poorly executed by the ANAO which found Services Australia delivery only “partly effective”.

Key facts & findings from the 2025 ANAO Report on the Delivery of the PBS:

1. As of 30 June 2023, there were 928 medicines (across 5,261 brands) listed on the Schedule of Pharmaceutical Benefits.

2. Budgeted expenditure for the PBS for 2024–25 was **$19.5 billion** (excluding recovery revenue).

3. In 2022–23, there were 223.1 million over co-payment PBS prescriptions (67.9 per cent) and 105.6 million under co-payment PBS prescriptions (32.1 per cent) dispensed in Australia.

The ANAO found arrangements to manage the delivery of PBS services and payments are *partly effective.* Deficiencies related to ensuring legislative requirements for certifying claims are met and performance reporting.

There were seven recommendations to improve the administration of the PBS — three to Health, two to Services Australia and two to both entities. Services Australia did not agree to one recommendation. [*This was the one on OPA- which the MSIA has recommended a solution for years ago*].

29.4% of PBS medicines require prescribers to gain authority approval from Services Australia prior to prescribing. These are the OPA which account for **$5.733B.**

The Australian National Audit Office (ANAO) report on the administration of the Pharmaceutical Benefits Scheme (PBS) scrutinized the processes surrounding online prescription authorities, focusing on the efficiency and effectiveness of authority approvals. The report identified significant concerns regarding the timeliness of these approvals, which are essential for patient access to certain medications.

Key Findings:

Timeliness of Authority Approvals: The ANAO observed that the existing performance measures for authority approvals were not aligned with the agreed targets. Specifically, the report highlighted that Services Australia's performance metrics did not reflect the goal of issuing authority approvals within 30 seconds, as stipulated in bilateral agreements.

Surge in Online Authority Requests: There has been a notable increase in the use of the Online PBS Authorities system, accessed via Health Professionals Online Services (HPOS). This shift indicates a preference among healthcare providers for digital channels over traditional phone-based methods, likely due to efficiency and convenience.

Recommendations:

To address these issues, the ANAO made specific recommendations:

Performance Reporting Alignment: Services Australia should align its reporting on the timeliness of issuing authority approvals with the agreed performance measures and targets. This alignment would ensure transparency and accountability in meeting established service standards.

Inclusion in Annual Performance Statements: The timeliness of authority approvals should be included in Services Australia's annual performance statements. This inclusion would provide stakeholders with a clear understanding of the agency's efficiency in processing these approvals.

Implications:

The misalignment between performance targets and reporting can lead to inefficiencies in processing authority approvals, potentially delaying patient access to necessary medications. The increasing **reliance on online systems underscores the need for robust digital infrastructure and responsive service delivery to meet healthcare providers' expectations.**

Addressing these recommendations is crucial for enhancing the efficiency of the PBS and ensuring timely access to medications for patients.

The MSIA submission to the Services Australia and Department of Health suggest a fully integrated OPA. Just as online PBS was not fully embraced in 2006-2007 until it was fully integrated, so too should the OPA be integrated with each provider system using internationally adopted standards like SMART on FHIR.

Adopting this recommendation would enable Services Australia to achieve the timeline and reporting targets recommended by the ANAO, improve productivity of the health sector, and most importantly, improve the timeliness of medication to Australians.

Harnessing data and digital technology

The health sector produces roughly 30 % of the world's data yet struggles to appropriately manage it for better outcomes. Two issues dominate: fragmented privacy rules that create

Privacy reform

1. How is the Privacy Act operating to balance consumer privacy consideration while supporting the benefits associated with data sharing? Is the balance right?

The Privacy Act is principles based which is good, but there are areas which are confusing to users which reduces trust in appropriate sharing of data. Having Jurisdictional legislation further confuses the population. Harmonisation would be beneficial.

One area for immediate improvement could be to embed an outcomes-based "fair and reasonable" test in the Privacy Act and deem data sharing that complies with the Data Availability and Transparency Act (DAT Act) to meet that test by default. (See our uploaded submission on the Data Availability Transparency Act to the Department of Finance.

2. Are there any changes you would like to see to privacy legislation in Australia? Please provide details below.

Allow accredited health-techs to lodge a single digital services statement that satisfies OAIC, Therapeutic Goods Administration and Australian Digital Health Agency requirements. Again, reduce the duplication and increase harmonization.

Enable AI's productivity potential

1. How are you currently using AI? Please provide details of the context and uses.

Our membership is using AI for Administrative and clinical purposes. Prospection's real-world analytics returned a 419 % ROI and AU$1.19 million NPV in three years; Alcidion's Patientrack reduced cardiac arrests by 76 % at NHS Fife; Heidi Health's AI scribes shrank GP documentation load by 70 %. These examples—and many in Annex A—confirm that well-governed data and interoperable APIs unlock measurable productivity dividends.

Details of the uses and benefits and suggestions for reform are encapsulated in our 3 submissions in 2024 the TGA, Department of health Ageing and Disabilities and Department of industry Science and Resources. These are all uploaded for the TGA and can be found here:

30/10/2024 - DoHAC: Safe and Responsible Artificial Intelligence in Health Care – Legislation and Regulation Review

30/10/2024 - TGA: Clarifying and strengthening the regulation of Artificial Intelligence (AI)

04/10/2024 - DISR: Introducing mandatory guardrails for AI in high-risk settings: proposals paper

2. What challenges do you face in accessing or using AI? How can these challenges be overcome?

Ensuring access to a reliable legally usable body of data is a Stand-up a national sandbox operated by ADHA and CSIRO where vendors can complete "test-once, accept-many" validation for cybersecurity, bias and SaMD performance, underwritten by vouchers covering 80 % of first-time test costs for SMEs.

Delivering quality care more efficiently

Quality improvement is fundamentally a data problem: clinicians cannot manage what they cannot measure. Yet clinical-safety regulation remains disparate and process-heavy, while funding rarely pays for the digital "last-mile" integration that turns raw data into actionable insight. Transactions and not outcomes are rewarded under Medicare Benefits items, and neither the Commonwealth nor Jurisdictions are willing to shoulder the cost of using digital health for preventative care despite the research demonstrating the safety, cost and productivity benefits.

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

To a great extent.

Offering levels of comprehension in the health workforce make the varying regulations challenging for part timers who could otherwise mobilise their skills more easily. Less workforce + less access to care.

Harmonisation of standards through a single National Clinical Safety Framework recognised by all jurisdictions and anchored in ACSQHC or ISO 14971 could improve this. Obviously, the federated nature of Australia brings challenges here without a corollary benefit, particularly given the fluidity of the population.

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

To a great extent.

Fundamentally quality and safety are national imperatives. The workforce is mobile. Having various regulations, when the same outcome of quality safe patient care is the goal for all, makes no logical sense.

3. What is your experience with collaborative commissioning?

Our membership responds to RFTs and collaborative commissioning.

Make interoperability KPIs—real-time discharge summaries, pathology events, medication-summary completeness—explicit eligibility criteria in pooled-fund pilots.

Although there is not a detailed report available yet, the recent commission by Defence for the shared care record appears to have been effective.

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

The responsibility of the Commonwealth Govt for primary health care and the Jurisdiction responsibility for Hospitals mean that there is rarely agreement on funding preventative help in primary care. It is called the blame game and has been called out by The Grattan Institute.

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

The National Health Roundtable estimates that preventable hospital readmissions cost AU$1.5 billion annually. Digital early-warning systems such as Alcidion's and AI-enabled rehab platforms such as Cardihab's have already demonstrated double-digit reductions in readmissions, pointing to at least AU$450 million in potential savings if deployed nationally.

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

- Reward outcomes not transactions via Medicare.
- Consider the legalisation of primary care rebates/ preventative health through private health insurance.
- Harmonise regulations for certainty and investment.
- Provide funding for software companies to educate and implement their products to give consumers more autonomy and information so they can observe and measure their health.

Proposed Implementation Road-Map for consideration incorporating responses to Pillars 1, 3 and 4

The reform package is designed to be budget-neutral within four years by redirecting existing digital-health funds and leveraging private capital. Key milestones are shown in Table 1.

Quarter	Deliverable	Lead
Q4 FY 24-25	Legislate SourceIT-Lite; launch SME Credit-Guarantee pilot	Finance / Treasury
Q1 FY 25-26	Issue Tiered Accreditation Rules & National Data-Governance Certificate criteria	Health / ADHA / OAIC
Q2 FY 25-26	National data & AI sandbox operational; first GovData-Ready certificates issued	ADHA / CSIRO
Q3 FY 25-26	Care-Quality Data Incentive payments commence; outcomes dashboard live	Health / Services Australia

Conclusion

Digital health is not a cost centre; it is the principal enabler of a safe, sustainable and patient-centred health system.

By adoption of the proportional, outcome-driven reforms set out above, Government will liberate billions in productivity gains, strengthen sovereign capability and position Australia as the safest, fastest place to turn health data into public good.

MSIA and its members stand ready to co-design, deliver and evaluate each element of the roadmap. Our productivity Survey and Productivity Capability Schedule will be provided following the Interim Report by the Productivity Commission.

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Annexure A

Annexure A will be completed in full following the interim Report and formal consultation by the Productivity Commission.

Company	Evidence	Link
Acredia	Signature Care eNRMC rollout reports cost savings versus multiple systems.	https://insideageing.com.au/signature-care-rolls-out-acredia-enrmc/
AlayaCare	Visit Optimizer AI scheduling cut admin 98 %, lifted fulfilment 35 %.	https://alayacare.com/press-release/home-based-care-providers-see-98-productivity-increase-with-visit-optimizer-from-alayacare/ https://alayacare.com/en-au/press-release/client-intelligence-suite-australia/ https://alayacare.com/en-au/press-release/alayacare-interoperability/ https://alayacare.com/revolutionizing-home-care-alayacare-launches-layla-an-ai-powered-assistant/ https://www.youtube.com/watch?v=BqAMh5FsO9M
Alcidion	Monash University and Digital Health CRC implementation at Alfred Health with significant benefits	https://www.alcidion.com/news/an-independent-study-shows-the-ripple-effect-of-benefits-from-adopting-a-patient-flow-management-solution/
Altura Health	Doctors on Demand platform delivered 700 k virtual GP visits, slashing waiting-room time.	https://www.doctorsondemand.com.au/online-doctors/
Avant	PracticeHub digital governance reduces policy admin; clinics report hours saved weekly.	
Best Practice	Bp Premier efficiency toolbar lets GPs finish notes within consult, reducing overtime.	https://bpsoftware.net/blog/bp-premier-efficiency-features/
Bestmed	BESTMED PMS automates chronic-disease plans; clinics see 30 % admin reduction.	[link coming]
Cardihab	Digital cardiac-rehab improves completion & trims readmissions; PC cites ‘significant cost savings’.	https://www.pc.gov.au/research/completed/digital-health
Carelink	CarelinkPlus schedules 3 000 carers in minutes vs hours, streamlining home-care rostering.	[link coming]
Cerner Oracle Health	Oracle Health Clinical AI Agent reduced physician documentation time by ~30 % across 30+ specialties.	https://www.oracle.com/news/announcement/physicians-reduce-documentation-time-with-oracle-health-clinical-ai-agent-2025-03-04/

Chamonix	Chamonix partners with government to enhance safety, productivity, and efficiency through secure, cloud-first solutions, collaborative co-design, and modern delivery techniques.	https://www.chamonix.com.au/government
Cubiko	Maple St Surgery uncovered AU$100 k unbilled items in 10 minutes via Cubiko dashboards.	https://www.commbank.com.au/business/insights/touchstone-cubiko-case-study.html
Dedalus	Lorenzo EPR paper-lite rollout cut MRSA cases from 22 → 4 per year at UHMBT.	https://www.digitalhealth.net/2012/10/think-again-about-lorenzo/
Doctors on Demand	Virtual GP & prescription service rated 4.7★ (218 k reviews); delivers same-day scripts & referrals.	https://www.doctorsondemand.com.au/online-doctors/
Edify	Immersive VR training replaces scarce sim labs, accelerating clinical competency uptake.	https://www.edify.ac/solutions/healthcare
Eucalyptus	Patient Adherence Loop automates outreach across 1 M+ telehealth consults, boosting adherence.	https://eucalyptus.vc/blog/how-pal-improves-patient-adherence
Foxo	Secure messaging delivered significant workflow efficiencies within 30 days for radiology groups.	https://foxo.com
Genomical	GIMS pipelines cut pathologist interpretation ~30 min/test across 22 k genomic tests.	[link coming]
Halo Connect	Integration pipes pathology results direct into GP software; reduces result-turnaround delays.	https://haloconnect.com.au/pathology-integration-for-gps/
HealthTeams	Remote-care hub consolidates tele-consults, vitals & comms, slashing GP travel and phone tag.	https://healthteams.com.au/
Heidi Health	AI scribe reduced charting time 70 %, freeing 100 clinician-hours in 14 weeks; 600 % ROI.	https://www.heidihealth.com/customers/priority-physicians
HotDoc	Online bookings cut reception phone workload by ~30 %.	[link coming]
iCare	iCareHealth eNRMC saves 45 minutes per medication round in aged-care.	[link coming]
InfoMedix	Digital medical record scanning delivers ~10-second retrieval vs paper file searches.	[link coming]
InterSystems	TrakCare unified record eliminates faxed notes & duplicate tests across NT Health.	https://www.intersystems.com/anz/customers/nt-health-single-digital-record/

Kestral	Auslab LIMS rollout improved lab turnaround times by 25 %.	[link coming]
Leecare / SimpleMed	Mobile audits & SimpleMed eNRMC cut med rounds 40 % at Amana Living.	https://leecare.co.uk/wp-content/uploads/2022/09/Leecare-Platinum5-Brochure.pdf
Magentus	Evolution vLab will manage 100 M tests/year, connecting 93 labs & wiping duplicate orders.	https://digitalhealth.net/2024/02/magentus-to-provide-lims-for-nhs-scotland/
MedAdvisor	Script reminder app raises adherence by ~20 %.	[link coming]
MIMS	Real-time interaction alerts reduce prescribing errors & downstream re-work.	https://cds.mims.com/hospitals-healthcare-systems
Minfos	POS-dispense sync speeds checkout and inventory reconciliation for pharmacies.	[link coming]
Modeus	MethDA compliance app digitises narcotics register, removing paper handling.	[link coming]
Montu	Digital telehealth & logistics scaled workforce 15× in 18 mo; serves 150 k patients/yr.	https://blog.hibob.com/case-studies/montu/
MPS Connect	e-meds platform integrates charts & pharmacy for 500+ aged-care homes, reducing errors.	https://mpsconnect.com.au/aged-care/
Oracle Health	See Cerner Oracle Health entry.	https://www.oracle.com/industries/health/
Orion Health	Amadeus shared-care record saves clinicians ~30 min searching disparate systems.	[link coming]
Packapill	On-demand pharmacy delivery within 3 h lowers abandoned prescription rates.	[link coming]
PalCare	Palliative EMR auto-generates ACC reports, saving nurses hours weekly.	[link coming]
Person Centred Software	Mobile Care Monitoring saves carers 90 min/day & nurses 4 h/day.	https://personcentredsoftware.com/au/case-studies/handsale-care-homes/
Prospection	Real-world evidence analytics delivered 419 % ROI and $1.19 m NPV in 3 yrs.	https://prospection.com/case-study/tei/
Qscan	Foxo integration lets referrers contact radiologists instantly, speeding reports.	https://www.qscan.com.au/foxo

RLDatix	DCIQ boosted incident reporting 16 % & near-miss capture 11 % at JH Aramco.	https://resources.rldatix.com/case-studies/johns-hopkins-aramco-healthcare-case-study
S4S Touchstone	Audit4 extracts automate CKD registry reporting, avoiding manual chart audits.	https://kidney.org.au/CKD-surveillance-project-audit4
Scrypt	Mobile e-script wallet forwards scripts direct to pharmacy, cutting queues.	https://scrypt.com.au/pharmacy
Silknote	Speech-to-text saves clinicians ~2 h/ day on documentation.	https://silknote.com/
Telstra Health	51% reduction in hospital readmission risk, a 3.2-day decrease in average length of stay, and an average saving of $3,698 per admission through virtual care technology. 40% reduction in medication round times and 10 hour reduction per day on documentation via our aged care solutions. A 30% drop in unexpected readmissions and a 10% increase in NEAT compliance through ourPatient Flow Manager solution. Replacing 17 separate billing systems with one enterprise-wide platform to enhance efficiency and consistency with PowerHealth's PBRC solution.	
Tyro Health	Integrated claims processing speeds rebate reconciliation & cash-flow.	[link coming]
Visual Outcomes	Automated KPI emails replace manual spreadsheets for multi-site clinics.	https://visualoutcomes.com/news/
VitalHub	SHREWD Vantage dashboards provide real-time demand views, reducing ED handover delays.	https://uk.vitalhub.com/products/shrewd-vantage/
Webstercare	MedsPro® blister-packing robot lifts pharmacy productivity 70 % & cuts overtime 11 %.	https://www.webstercare.com.au/products/medspro/

The Medical Software Industry Association of Australia (MSIA) powers healthcare in Australia.

2025 Brief to Incoming Government