Australian Government
Productivity Commission

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Pillar 4
Delivering quality care more efficiently

Consultation questions | May 2025

Contents

Delivering quality care more efficiently

Care services are essential to our lives and the economy. With the workforce and budgets under pressure, we are looking at ways to deliver quality care more efficiently.

We are asking you for feedback on our approach so far to **Pillar 4: Delivering quality care more efficiently**.

After reviewing the ideas submitted through Australia's Productivity Pitch and undertaking our own research and stakeholder consultation, we have identified three policy reform areas in this pillar to explore further.

For each reform area, we will:

- recommend specific reforms
- seek to quantify their benefits (where possible) and
- suggest how the reforms can be implemented.

Reform of quality and safety regulation to support a more cohesive care economy We are interested in the scope for greater alignment and streamlining of quality and safety regulation across the care economy while driving high quality care.	**Embed collaborative commissioning to increase the integration of care services** Collaborative commissioning shows promise, but key barriers remain. We're exploring ways to embed it more effectively and make it truly collaborative.	**A national framework to support government investment in prevention** We are looking at reforms that would support government investment in prevention programs to improve outcomes for the community and reduce demand for future services.

Why is delivering quality care more efficiently important?

The care economy is a vital part of our lives, providing services that millions of Australians depend upon. Services like healthcare, aged care, community services, veterans' services, services for people with disability, and early childhood education and care ensure our health, wellbeing and quality of life.

The importance of the care economy is growing, with more Australians relying on its services than ever before. Demand is increasing due to an ageing population, an increase in chronic and complex illness, and a shift from informal to formal care in sectors such as aged care, childcare and disability support.

Australian Government spending on aged care, disability, early childhood education and care and health services is projected to grow from around $216 billion in 2024-25 to around $247 billion in 2027-28. States and territory governments' spending on care services is also expected to increase substantially with anticipated changes to disability support.

A more efficient care economy will help to reduce the pressure on the workforce and governments and enable improvements to the quality of care that people receive. To do this, we have looked at opportunities to reduce duplication and close gaps, make better investments in prevention, and ease the regulatory burden on workers and providers.

What are the pillars of productivity?

In 2024, the Australian Government asked us to identify the highest priority reform areas under 5 pillars of productivity:

1. Creating a more dynamic and resilient economy
2. Building a skilled and adaptable workforce
3. Harnessing data and digital technology
4. Delivering quality care more efficiently
5. Investing in cheaper, cleaner energy and the net zero transformation.

We will deliver practical and implementable policy ideas across the 5 pillars at the end of 2025.

Sub-page – Policy reform area

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

Quality and safety regulation helps ensure that care users receive the services they need and deserve. They provide a level of assurance to care users and help them make informed choices.

Currently, rules, standards and regulatory processes can differ across care sectors and jurisdictions. While there may be good reasons for these differences, they can also impose high regulatory burdens on those navigating multiple sectors or locations and make the care economy less efficient and effective. For example, requiring providers to register multiple times to provide similar services in different sectors may lead them to only operate in one sector, leaving care users with fewer choices. Separate registration systems for different sectors and a lack of communication between regulators can also mean that unsafe providers fall through the cracks.

Aligning or streamlining quality and safety regulation in the care economy could make it easier for providers and workers to operate across sectors, giving users more choice and assurance that they will receive the care that best meets their needs.

Our approach

We will explore ways to align safety and quality regulation, while ensuring it remains effective, to enhance the cohesiveness of the care economy. We will look at:

- ways to improve how regulators work together, including how they share information and recognise each other’s decisions
- opportunities to streamline processes to reduce duplication across sectors, including in relation to providers and the care economy workforce
- how safety and quality regulations could be better aligned or made more consistent across the care economy to drive improvements in safety and quality.

We are not examining whether the regulations in each sector are appropriate, and we recognise there can be differences across sectors that justify different regulation. However, where there are similar processes or services across sectors, we will consider opportunities for alignment or streamlining.

Sub-page – Policy reform area

Embed collaborative commissioning to increase the integration of care services

Enabling new approaches to delivering care can lead to higher quality and more cost-effective outcomes, improving productivity in the care sector.

'Collaborative commissioning' involves care agencies and organisations working in partnership to identify and respond to a population's care needs. Agencies and organisations may design solutions and procure services that are responsive to a community's needs, and work together to evaluate service outcomes. Collaborative commissioning can reduce gaps and avoid duplication of services by taking a holistic view of the needs of a population, which can help deliver quality care more efficiently.

Contracting and funding requirements can limit the potential for coordination and collaboration with other tiers of government or across departmental and agency lines of responsibility. The consequences of this are particularly significant where vulnerable populations have trouble accessing the right type of care.

Collaborative commissioning is not a new idea. For example, greater collaboration has been flagged in the National Health Reform Agreement. Notable other examples include NSW Health's collaborative commissioning initiatives and the trials underway under the recent Australian Government Integrated Care and Commissioning initiative. Despite these initiatives, there is scope to better integrate care and embed collaborative commissioning across the Australian care economy.

Our approach

We will examine how collaborative commissioning can improve the efficiency and quality of care services and how to better embed it across the care economy.

We will also explore what helps or hinders effective collaborative commissioning, analyse the suitability of various approaches for different contexts, and investigate opportunities for collaborative planning and integration across sectors, such as health, disability, veterans and aged care.

We are particularly interested in the potential for further collaboration in commissioning care services between Primary Health Networks, Local Hospital Networks, and Aboriginal Community Controlled Health Organisations.

Sub-page – Policy reform area

A national framework to support government investment in prevention

Evidence-based prevention programs can drive productivity in the care sector and the wider economy by providing services that aim to reduce a person's future demand for care services. When they're working well, prevention programs reduce risk factors before problems arise (primary prevention), help detect issues early (secondary prevention) or slow the progression of disease or other issues during initial stages (tertiary prevention).

Despite their benefits, governments are often reluctant to invest in prevention programs. Funding decisions tend to prioritise immediate needs and align with the responsibilities of specific departmental portfolios. Prevention requires governments to spend upfront while benefits can take time to be realised, are hard to measure and can span different parts or tiers of government. For example, investment in support services for people at risk or experiencing homelessness can lead to long-term savings through improved health outcomes and reduced future demand for other services.

A framework that measures and incorporates the long-term benefits of prevention could encourage greater investment in evidence-based prevention programs. Such an approach could improve outcomes for people through timely and effective support and enhance the sustainability of the care economy.

Our approach

We will consider the features of a framework that would allow for investment in prevention based on a broad and long-term assessment of potential benefits.

We are particularly interested in:

- barriers to government investment or scaling up of effective prevention programs
- the extent to which inadequate funding and the short-term or limited assessment of benefits has restricted effective prevention
- the extent to which the benefits of prevention accrue across different sectors and/or tiers of government
- policy actions that could support greater investment in prevention activities.

Sub-page – Consultation page with online form

Have your say on how to deliver quality care more efficiently

Section 1. About you and/or your organisation

In this section, we want to understand how you interact with the care economy, including which sectors and in what jurisdiction(s).

You will also be asked to select the reform area(s) you are interested in responding to.

Contact information

1. **Name** Australian Commission on Safety and Quality in Health Care
2. **Email** mail@safetyandquality.gov.au cc to ACSQHCIGR@safetyandquality.gov.au
3. **Phone** 02 9126 3600
4. **Postcode** 2000
5. **May we contact you about your response?**
   - Yes
   - No

If yes:

6. **How would you prefer we contact you?**
   - Email
   - Phone
   - Other (please specify)

Attribution

7. **Whose views does your response represent? (Please include the full names of applicable individuals, groups or organisations).**

Australian Commission on Safety and Quality in Health Care.

8. **Do any of the attributed parties identify as Aboriginal or Torres Strait Islander/are any identified organisations an Aboriginal and/or Torres Strait Islander organisation?**
   - Yes
   - No
   - Prefer not to say

Consent

9. Do the attributed parties consent to the PC publishing your response on our website and referring to it in our reports?

- Yes, with attribution
- Yes, without attribution
- No, do not publish my response or refer to it in your reports

We will only publish your response if it meets our community guidelines. We are unable to refer to unpublished responses within our report.

For further information on how we handle your information visit our Privacy Policy and Information Policy.

10. Guidelines and policies agreement

- I have read and agree to the above guidelines and policies.

Providing supporting documents (optional)

At this stage of the inquiry, we are only accepting and reviewing supporting documents that meet the following criteria:

- They contain data, charts and supporting information relevant to the policy areas and questions we are asking in this round of consultation
- The attributed participant(s) hold the copyright for the information contained in the documents
- The documents don't include any personal or identifying information.

There will be an opportunity to provide submissions on our policy reform ideas when we release our interim report.

11. Will you be providing any documents to support your response?

- Yes **via website linkage outline in our response**
- No

How to provide a supporting document

Once you have submitted your response via the 'Submit' button below, you will receive a confirmation email from us. Please reply to this confirmation email with your supporting documents attached.

For accessibility reasons, we prefer Microsoft Word documents.

Once we receive your supporting documents, we will review them alongside your response. If your contributions meet our community guidelines, and you have provided consent, we will publish them to engage.pc.gov.au within 14 days.

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

- I am a consumer or user of care services (consumer)
- I am a carer of someone who uses care services (carer)

- I am a care worker
- I am an organisation that provides or coordinates care services
- I am an industry or advocacy organisation, professional association or peak body
- I am a government department/agency
- I am an interested community member

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

- Aged care
- Disability
- Early childhood education and care
- Health
- Veterans
- Aboriginal Community Controlled
- Other (please specify)

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

Federal Government

4. We are seeking responses to questions on three policy reform areas.

Which policy reform areas would you like to respond to?

- **Reform of quality and safety regulation to support a more cohesive care economy**

  The care economy workforce and providers are subject to a suite of rules, standards and policies that are intended to ensure safe and high-quality care.

  While there are good reasons for this, it can also add to complexity and costs when navigating multiple sectors and jurisdictions.

  We are interested in your views on the extent to which this is a concern and what you might change.

- **Embed collaborative commissioning to increase the integration of care services**

  Collaborative commissioning is the process of organisations working in partnership to identify care needs, design solutions, procure services and evaluate outcomes.

  We are interested in opportunities to improve collaborative commissioning across care sectors – such as health, disability and aged care – to reduce gaps and achieve better outcomes.

  As a starting point, we are interested in the potential for greater collaboration between Primary Health Networks (PHNs), Local Hospital Networks (LHNs) (also known in some jurisdictions as Health Service Providers, Hospital and Health Services, Local Health Districts, Local Health Networks or Local Health Service Networks) and Aboriginal Community Controlled Health Organisations (ACCHOs).

- **A national framework to support government investment in prevention**

Governments can often underinvest in prevention and early intervention because the benefits of these programs can take a long time to materialise, can be hard to measure and can be spread across different areas and levels of government.

We are interested in exploring policy approaches that support greater government investment in prevention activities and that measure and incorporate the long-term and community-wide benefits.

Section 2. Reform of quality and safety regulation to support a more cohesive care economy

In this section, we are seeking feedback on how differences in the regulation of safety and quality across the care economy may create cost and complexity for workers, providers and users navigating multiple sectors. These impacts may arise from differing requirements for processes such as worker screening, provider registration, audits, developing behaviour support plans and regulatory reporting.

We are not examining whether the regulations themselves are justified or whether standards are appropriate across sectors – we recognise there may be differences across sectors that justify different regulation.

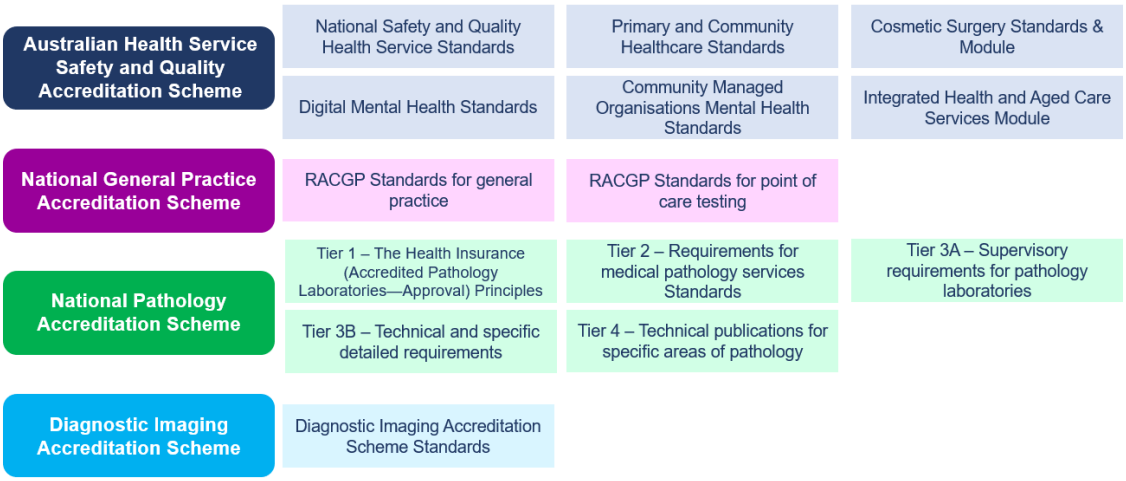
Our focus is on whether there is scope to better align regulations or streamline processes to improve outcomes for people receiving care.

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

- Not at all
- Very little
- Somewhat
- To a great extent

6. What are the reasons for your answer?

The Australian Commission on Safety and Quality in Health Care (the Commission) is responsible for the development of national safety and quality standards for healthcare services across different sectors. The Commission coordinates the accreditation of healthcare services under four different schemes:



Accreditation enables the collection and reporting of data that can be used to inform decisions about safety and quality improvements nationally, by states and territories and at a local level. It can be used to improve transparency and support patients to make informed decisions about their care. The Commission uses feedback to identify areas where health services may require additional support or tools and to maintain and update the safety and quality standards developed by the Commission.

The overarching principles that govern this work is that:

- Standards drive change and provide a framework for safety and high-quality care
- Accreditation verifies that changes are made, and safety and quality is maintained
- Accreditation provides assurance to funders and Commonwealth incentive programs that eligible services are meeting expected standards of care.

Through the Commission's coordination of these accreditation schemes, opportunities to streamline processes to reduce duplication across sectors have been identified and implemented. An example of the work we have done to align the health care and aged care standards is provided below:

Integrated Health and Aged Care Services Module

The Integrated Health and Aged Care Services Module (the IHACS Module) is due for release in June 2025, with implementation to begin from 1 July 2025. Health service organisations delivering acute, emergency and sub-acute health services must be accredited to the National Safety and Quality Health Service Standards (NSQHS Standards). Organisations delivering Commonwealth-funded aged care services must comply with the strengthened Aged Care Quality Standards (ACQ Standards), as applicable to their service type.

The Commission has developed the IHACS Module to supports approved organisations to streamline the process of meeting the NSQHS Standards and the ACQ Standards in a single assessment process. The IHACS Module was developed by mapping the outcome statements in the ACQ Standards to the actions in the NSQHS Standards Second Edition to identify the elements unique to the ACQ Standards. These elements are consolidated into 14 Module Items, which when assessed alongside the actions in the NSQHS Standards, allow services to be deemed accredited to both the NSQHS and ACQ Standards. This IHACS module is

an update the previous Multi-Purpose Service module, broadening the applicability to more health and aged care services.

There are however multiple other standards, with overlapping requirements and slightly varying compliance requirements, timelines and formats that health services are required to implement. These include disability standards, standards from professional organisations for clinical training, aged care standards, ISO 9001and Standards Australia standards, drug and alcohol standards.

There would be significant productivity gains from rationalising the number of standards required, removing the overlap in requirements, streamlining assessment processes and mutual recognition across programs

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

- Not at all
- Very little
- Somewhat
- To a great extent

8. What are the reasons for your answer?

- The Commission has worked with stakeholders to standardise safety and quality regulatory requirements. For example, the National Safety and Quality Primary and Community Healthcare Standards have been embedded into the Pharmacy Guild Practice Standards and the Commission is working with the Royal Australian College of General Practice to include these standards into their practice standards.
- While there are areas where safety and quality regulations can be aligned, regulations need to take account of the specific risks, service context and patient requirements in different health sectors.
- For example, compliance with safety and quality standards for small practices and services can present a significant burden not as evident in large multifaceted services.

Digital health

Various efforts to build national digital health enablement and infrastructure has highlighted the unique requirements of the health (all sectors), disability and broader social care domains. Regulation aimed at ensuring a more cohesive care economy is wholly consistent with the objectives of whole of health system interoperability and digitally enabled care. Examples of digital enablement that could be the subject of regulation could be healthcare identifiers that can be reliably ‘machine read’, irrespective of where in the economy a consumer might present for care.

Section 3. Embed collaborative commissioning to increase the integration of care services

In this section, we are seeking feedback on collaborative commissioning, which is the process of organisations working together in partnership to identify care needs, design solutions, procure services and evaluate outcomes.

We are interested in opportunities to improve collaborative commissioning across care sectors – such as health, disability and aged care – to reduce gaps and achieve better outcomes, but are particularly interested in the potential for greater collaboration between Primary Health Networks (PHNs), Local Hospital Networks (LHNs) (also known in some jurisdictions as Health Service Providers, Hospital and Health Services, Local Health Districts, Local Health Networks or Local Health Service Networks) and Aboriginal Community Controlled Health Organisations (ACCHOs).

9. What is your experience with collaborative commissioning?

The Australian Commission on Safety and Quality in Health Care (the Commission) does not directly commission healthcare services. However, the Commission does undertake healthcare variation data analysis and creates national frameworks and standards, all of which are essential for targeted and effective collaborative commissioning.

For the Heavy Menstrual Bleeding (HMB) clinical care standard (CCS), for example, the Commission's associated Women's Health Focus Report | Australian Commission on Safety and Quality in Health Care enabled targeted communication with PHNs with the greatest variations in hysterectomy rates. Engaged PHNs could then utilise the Commission's Primary Health Networks Implementation Guide - Heavy Menstrual Bleeding Clinical Care Standard | Australian Commission on Safety and Quality in Health Care. This is not a passive document, but a toolkit for action. It encourages PHNs to use the Focus Report data to investigate local practice, promote the standard through their networks with ready-made campaign materials and clinician presentations, and review or localise their HealthPathways to align with the standard's recommendations.

Another example is the release of the Chronic Obstructive Pulmonary Disease (COPD) CCS, with its emphasis on spirometry for COPD diagnosis. This helped catalyse a collaboration between WA Health and Respiratory Care WA. This collaboration has enabled access for adults to zero-gap spirometry through the expansion of Respiratory Care WA diagnostic hubs and creates a template for other states and territories to follow.

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

There are precedents for collaborative commissioning between PHNs and LHNs as being effective vehicles for positive change. One particularly successful example is the Diabetes Alliance Program Plus (DAP+), involving Hunter New England Local Health District (HNELHD) and the Hunter New England and Central Coast Primary Health Network (PHN), where the collaboration has allowed, *"…cross-organisational sharing of skills, knowledge, and resources to develop a person-centred model of care that is efficient, cost-effective, and sustainable…[and] has allowed primary care and specialist teams to work seamlessly to provide the best care in a team approach as close to home as possible for patients."*

By utilising a "one-health-system" lens, collaborative commissioning gives local health systems greater potential to coordinate data-informed, focused, less-fragmented regional efforts. The Commission is dedicated to pursuing initiatives and frameworks that foster such collaborations in ways that maximise the probability of realising measurable improvements in patient safety, health outcomes, and health equity.

11. 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?

- Clinical governance is the combination of culture, systems and processes that unites a health service's leaders and workforce to deliver care that is consistently high quality and improving.
- It is the system by which boards, executive and the workforce are accountable to patients and the community for providing high-quality care (care that is safe, effective, person-centred, accessible, efficient, integrated, sustainable and equitable).
- Effective clinical governance builds and sustains an environment and culture where working together and with patients, carers and consumers to provide high-quality care is everybody's main goal.
- Robust governance is needed to achieve the positive potential of collaboration between health services. Clinical governance needs to address safety and quality issues beyond hospital walls and across the continuum of care.
- The Australian Commission on Safety and Quality in Health Care is developing a new national model of clinical governance for health services. The model will describe what good practice looks like for integrated health care, and will note that a health service organisation's responsibility for patients includes the transitions of care.
- Clinical governance systems and structures should be designed to ensure the commissioning of safe and high-quality care services.

Digital health

From a digital health perspective, collaborative commissioning would be very welcome. Some examples exist where digital enablement initiatives are either duplicative and or would clearly benefit from collaborating early, including for commissioning of services for related outcomes.

Section 4. A national framework to support government investment in prevention

In this section, we are seeking feedback on how to support government investment in evidence-based prevention programs that improve long-term outcomes for the community and reduce demand for future care services.

Care services can play an important role in reducing or eliminating the effects of preventable problems. Prevention activities can reduce risk factors before problems arise, help detect issues early or slow their progression during initial stages.

Despite this, governments can be reluctant to invest in prevention because it requires up-front spending and the benefits often take a long time to materialise, can be hard to measure and can be spread across different areas and levels of government.

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

- Fragmentation between acute and community services and funding diversity.
- Acute services have limited resources to invest in preventive activities and have little incentive to do so, as their impacts may not be obvious or may be achieved downstream and be difficult to quantify at a health service level.

- Many prevention programs in the community are privately funded and therefore not accessible to people with the greatest equity gaps who may be most likely to benefit.
- A lack of integrated patient management incorporating allied health interventions and medical care, across care sectors results in inefficient and inequitable access to preventive activities.

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

- **Pulmonary rehabilitation programs for people with COPD**
  - *Chronic Obstructive Pulmonary Disease (COPD) Clinical Care Standard*
  - *See Jenkins AR, Burtin C, Camp PG, Lindenauer P, Carlin B, Alison JA, et al. Do pulmonary rehabilitation programmes improve outcomes in patients with COPD posthospital discharge for exacerbation: a systematic review and metaanalysis. Thorax [Internet]. 2024 Feb 13 (Epub ahead of print). Available from https://pubmed.ncbi.nlm.nih.gov/38350731/*
- **Prevention for low back pain prevention and management***:*
  - *Low Back Pain Clinical Care Standard*
  - *Prevention and treatment of low back pain: evidence, challenges, and promising directions Foster, Nadine EBuchbinder, Rachelle et al. The Lancet, Volume 391, Issue 10137, 2368 - 2383*
- **Osteoarthritis of the knee**
  - *Osteoarthritis of the Knee Clinical Care Standard and related resources (eg GLAD)*

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

Consider funding approaches that incorporate evidence-based preventive activities and programs that enable access from acute settings or the community, with a focus on models of care that span the continuum of care, better shared management and monitoring of patient outcomes (reporting).

Availability of clinical data quality is a fundamental enabler for understanding clinical services provision and being able to leverage that data, contributes to efforts to prioritise investment in prevention. The objective of collecting defined clinical data once and utilising it, subject to lawful data governance practices many times, supports efforts to invest in prevention.