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Overall, I think the recently released interim report on Care Efficiency is a good one, but I have the following comments:

1. I agree with the approach taken in Recommendations 1 and 3. My only suggestion is that you call out the use of distributional cost effectiveness analysis as part of Recommendation 3.
2. If you assume the opportunity cost of bureaucrats' time is zero, then Recommendation 2 will do no harm. However, in my view it is unlikely to go anywhere and is a waste of space. I recognise that this harsh assessment may be influenced by the fact I live in Victoria.
3. If the Commission is constrained to have only three priority areas, a far more important one is the collapse of allocative efficiency in the institutional sector. This has two components.
 - a. The dramatic growth in 'stranded patients', i.e. patients who do not need to be in public hospitals but are there because of failures in the aged care, disability, and homelessness sectors. The reciprocal interdependence between those sectors and hospital care warrants action and has far greater productivity improvement potential than 'collaborative commissioning initiatives'.
 - b. You might talk to your ROGS colleagues to quantify the issues but on my analysis, the growth in beds taken up by aged care waits over the last two years is the equivalent of a whole new teaching hospital.
 - c. You might also speculate about why Victoria has a negligible number of beds occupied by patients awaiting residential aged care. The glib answer is that it has retained a public sector residential aged care system. A better answer is the failure to design a reward system to encourage private sector services to respond to this need.
 - d. The second component is that, as you are aware, allocative efficiency can't be achieved without technical efficiency. It is a continuing sadness to me that activity based funding has been abandoned in the two largest states, and potentially other states too. Some analysis of that might also be warranted.