THE UNIVERSITY OF SYDNEY
Sydney Policy Lab

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The Productivity Commission
Submitted via online portal

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Dear Commissioners,

Feedback on *Delivering Quality Care More Efficiently Interim Report*

We are pleased to provide this response to request for feedback on the Productivity Commission's (PC) Interim Report on Delivering Quality Care More Efficiently.

The Sydney Policy Lab is a university-wide research institute at the University of Sydney. The Lab is community-centred in its approach and brings together diverse forms of expertise to solve major policy challenges. The Lab has a CARE Program led by Professor Brendan McCormack, Dean of the Susan Wakil School of Nursing and Midwifery. The CARE Program is focused on **C**hampioning **A**ustralia's **R**elational **E**conomy and has several initiatives that advance this agenda. Two of these are highly relevant to this pillar of the PC's inquiry: (i) Social Determinants of Health Innovation; and (ii) A partnership with SEED Futures on a National Primary Preventative Framework.

Our feedback on the interim report draws upon work across the CARE Program, including these two initiatives. We highlight aspects of the National Primary Preventative Framework, which will be the focus of feedback provided directly to the PC by SEED Futures in a separate response.

We commend the PC on the Interim Report and the major strides forward that it represents – firstly, engaging with the nature of the productivity challenges in the care economy arising from the fundamental human nature of care; and secondly, the long-awaited focus on a framework for government investment in prevention. It is hard to overemphasise the significance of these two developments, especially when the PC is pursuing them in tandem.

Our feedback is provided to assist the PC to further develop practical reforms that would improve Australia's wellbeing and living standards. Our response is focussed on Chapter 2: *Embed collaborative commissioning to increase the integration of care services*, and Chapter 3: *A National Framework to support government investment in Prevention.*

Chapter 2: Embedding collaborative commissioning to increase the integration of care services

Elevating community organisations in collaborative commissioning

The process of collaborative commissioning acknowledges both the intersection and siloing of care delivery systems. Successful collaborative commissioning is predicated on the notion that **care must be contextualised as provided first and foremost, in and through the Australian community**, before it becomes professionalised. We understand that to make the strongest possible case for primary prevention (a clear focus of the Interim Report), avoidance of future costs needs to be emphasised as starkly as possible to highlight how prevention can restrict the current rising trajectory of care costs. However, from a social policy perspective, when the centre of gravity in the trajectory of care provision reaches the apex of acute care and construes "the height of care" as that provided in a hospital bed, the most significant opportunities for practical reforms are lost. This is particularly salient when the central example of avoided cost is 'preventable hospitalisations' (p.44).

We commend the PC for acknowledging that, 'the benefits of prevention do not just accrue to people who are targeted but can generate spillover benefits such as reduced future service and support needs, reduced crime, improved labour productivity, higher employment, and better social cohesion' (p54). However, we contend that the benefits are not mere 'spillovers.' When care and the care economy is seen as serving people (not the other way around), and the care economy and provision of care as embedded in the centrality of people in society, broader community benefit is intrinsic to the whole endeavour.

Contextualising care in community opens the field of view in a very practical way when it comes to collaborative commissioning. There is a risk that this opportunity and the lasting benefits it provides will be missed with the narrow focus of the Interim Report on collaborative commissioning between Primary Healthcare Networks and Local Health Networks. We challenge the language of 'other organisations' which suggests that community-embedded organisations are peripheral to the collaborative commissioning process. **When care is seen properly within the context of community, these organisations are no longer peripheral – they are of strategic significance in representing the authentic voice and needs of community in collaboration.**

Realising the potential of these community-embedded organisations and properly co-designing in genuine partnership with them results in better outcomes for communities and we contend lowers costs. Non-government organisations (NGOs) and other community networks connect people to informal sources of support, point people towards health and well-being services and do much of the invisible, heavy lifting in supporting health-related productivity. Our research highlights the importance and significance of these organisations in acting as 'care navigators' in our complex and often non-person-centred health systems. We are continuing to implement and evaluate this, for example, in our Social Determinants of Health Innovation project in South West Sydney.

Investing in work that maps these networks and maximises their integration with larger care systems leverages existing community strengths, increases access to preventative care and directs people away from expensive acute care services and towards contextually appropriate preventative care. Capacity building may be required to upskill those involved in health leadership, workforce capability and policymaking to enable genuine co-design with communities and community organisations.

Request for Information: *How should the mismatched boundaries between LHNs, PHNs, ACCHOs and other organisations be addressed in implementing the different elements of the proposed reform?*

This mismatch in boundaries can be addressed by funding and incentivising programs that bring together these disparate organisations to understand and work together on practical problems. **Collaborative models of implementation** embedded in strength-based theories of community have been used throughout the world in health systems design with proven outcomes. These models are underpinned by a philosophy of **collaboration, inclusion and participation (CIP)** of all interested parties. Such models are underpinned by **Co-design methods** which have proven evidence of breaking down some of these artificial boundaries, when done well. They identify shared system understandings to address the expressed needs of people engaging in different parts of the system, while allowing more integrated solutions that reduce service duplication and leverage community strengths. Creating the conditions for effective multisector co-design for a single project can establish a structure and relationships for learning that can be applied to ongoing system co-design. **The CARE Program is underpinned by collaborative models of implementation, CIP and co-design methods and we would be keen to share our expertise further.**

Request for Information: *How can this proposed reform be employed to further integrate and expand place-based approaches across the care sector?*

We commend the PC report and the value it attributes to place-based work. Australian communities are marked by considerable diversity and are distributed across a vast geographic area. To deliver quality care more efficiently, **place-based approaches to care need to be funded by Government – with a shift from positioning these as either pilots or proof of concept, to being locally validated and integrated into health and care systems**. The underlying challenge is that Australia's current universalist design for health and social systems requires significant disruption to meet the specific needs of cohorts and communities, whilst still aligning care with best evidence, and within regulatory constraints. Effective and sustainable placed-based work often arises from locally driven research evidence with a focus on lived experience, but traditional research funding schemes such as those of the NHMRC do not always value this type of evidence, or indicators for success that are meaningful to communities. Similarly, the goals of philanthropic funding bodies do not always align well with government organisations and programs.

Expanding place-based approaches in a rigorous way could be achieved by firstly communicating an expectation for local 'holding containers' that provide a locally relevant structure for cross-sector system assessment and design. These structures should incorporate Local Health Districts/Networks, Primary Health Care Networks, Aboriginal Community Controlled Organisations (ACCHOs), community organisations, and community members with lived experience of the relevant issues. These community stakeholders should be trained for, and supported in, their preferred roles and be equally represented alongside professional stakeholders to give them a meaningful rather than a tokenistic voice. These stakeholders are often referred to as 'peer-researchers' and 'citizen scientists'. Ideally, local policy makers are also engaged in this process. Members of the CARE Program have extensive experience of working with peer-researchers, lived-experience researchers and citizen scientists and these methodologies underpin our established ways of working. **We are happy to provide further information and evidence as needed.**

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Expanding place-based approaches

Program evaluation methods such as Realist Evaluation can identify 'what works for whom in what circumstances and why', deriving key principles from place-based innovations and projects that can be decontextualised and then recontextualised to other settings. Such models of evaluation extract the learning from place-based implementation and the outcomes arising as 'principles' that can be applied in other contexts and settings. This allows a more confident selection of projects that are suitable for scaling and flags elements that can be adapted to different contexts. Embedding this approach makes funding small initiatives less risky and provides the basis for longer term funding.

Chapter 3: A National Framework to support government investment in prevention

A framework for government investment

The Policy Lab's collaboration with SEED Futures proposes a National Primary Preventative Framework. In developing this Framework, SEED has heard consistently through extensive consultations how **critically important** it would be to **first have a framework for government investment in prevention, prior to any funding mechanisms being created and funding committed**. This point has been a distinctive feature of the approach taken by Victoria in the establishment of an 'Early Intervention Investment Framework' (EIIF) and is a key point of their advocacy. We lend our support to this approach.

A national framework for government investment in prevention, broadly, would enable the nested development of more focused strategies within this architecture. Importantly, it would provide guidance to multiple actors, both governmental and non-governmental across and between each jurisdiction. Further, such a framework would enable the design of a robust approach to modelling, cost allocations and incentives for collaboration. The Framework we have developed with SEED Futures to prevent disadvantage becoming entrenched for the most vulnerable and disadvantaged children (aged 0-5) and their families would be greatly assisted by the establishment of a National Framework, as recommended in the Interim Report. We would expect that if such a Framework be created, it would positively transform the conditions of numerous other systems relevant to social policy.

A pre-social services sector

SEED Futures **promotes a vision for a Pre-Social Services Sector** to address the entrenched disadvantage that limits the reach of prevention programs. This Pre-Social Services Sector represents a fundamental reconceptualization of how Australia approaches disadvantage, shifting from crisis response to preventing harm before it occurs.

The Pre-Social Services Sector would be anchored in primary prevention and structured around the five foundational conditions identified in the National Primary Prevention Framework: vision, trust, hope, Indigenous leadership, and incremental reform, alongside five enabling factors: place-based co-design, lived experience shaping policy, intergovernmental collaboration, adaptive evaluation / storytelling and transparent funding. This sector will set the agenda and implementation strategy for each condition and enabler as a national imperative, including coordinating investments across the

first 1000 days, childcare and early childhood education, juvenile justice, after-school care, youth services, and primary health care – ensuring that true prevention stems from collaborative, whole-of-sector investment rather than isolated program silos.

Program investment

We welcome the PC report's acknowledgement that prevention includes *"interventions in areas like housing, education, justice and family support services, recognising that actions in one policy area may have benefits in others"* (p.53). **It is only when policy and funding addresses social determinants that influence how the community engages with existing primary and secondary prevention strategies, that the greatest returns on government investment can be realised.** These social determinants are most effectively considered in the design of prevention programs when there is **meaningful inclusion of community organisations, and contributions from people with relevant lived and living experience**.

Funding bodies and collaborations between partners that have a track record supporting cross-sector system change is offset by the resulting productivity benefits. Larger scale systems work often includes universities and institutes with specific program and research expertise that can upskill health and community teams and assist with program evaluation. An example of a funding mechanism might be supporting or incentivising a funding round that attracts applications for co-designed actions and research that engages multiple sectors in prevention initiatives. Co-design training and facilitation comes at a cost and is another worthy focus for investment.

Assessment and evaluation of programs

We strongly agree with the report's assessment that in the care economy, quality should be recognised as a marker of productivity. When people experience quality healthcare, this positively impacts their future care-seeking behaviours and improves primary and secondary prevention outcomes.

Request for Information: *Should alternative approaches be considered for governance of the framework, including institutional setting, processes for arriving at co-funding arrangements, decisions and evidence requirements?*

It is pleasing to see the call for a standard actuarial model to evaluate funded programs (which would be a useful resource) is **not intended as the only measure of program success**. The more flexible evaluation requirements for smaller programs, including alternative success measures in line with the size, significance and risk of initiatives **gives co-designed programs the flexibility they need for success indicators to be collaboratively informed by receivers of care**.

Evidence requirements should be flexible enough to accommodate collectively determined indicators of success arrived at through collaborative and co-design process. Government funded models of evaluation need to move beyond simple input-output-outcome models of effectiveness. Instead, system improvement evaluation needs to be embedded in social models of evaluation (such as Realist Evaluation) that determine why (some) programs work, for whom, in what circumstances, and why? Such models increase the transferability of key findings without reducing the rigour of the process. **Members of the Lab's CARE Program have extensive experience of utilising such models**

of evaluation and can demonstrate outcomes that are socially embedded and sustainable over time.

Request for Information: *What considerations would ensure that the framework works together with existing prevention programs funded by states and territories? How can the framework encourage governments to keep supporting existing effective prevention programs?*

A mapping exercise should make visible existing prevention programs with evidence of success and consider the performance indicators used to measure those programs. This could expand the repertoire of measures available for consideration in the framework, and capture the evidence behind existing programs.

In conclusion, a National Framework must be co-designed with groups who have extensive experience developing prevention frameworks for specific cohorts and priority areas. The Framework should be developed from the ground up, informed by the lived realities and specific needs of priority cohorts and areas for primary prevention, ensuring it is evidence-based and genuinely responsive to those most at risk of entrenched disadvantage. This must be a framework, not just funding. We believe that such a framework has the potential to traverse the lifecourse and ensure preventative strategies are prioritised at all stages of life.

Australia now stands at a decisive juncture: continue a costly crisis response or pivot towards prevention-first models that maximise social and economic returns. Without decisive investment in prevention through a structured national and holistic framework working collaboratively with existing state and territory programs, entrenched disadvantage will deepen social fractures and drive-up long-term costs. True productivity begins with children, families, and communities.

Yours sincerely,

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