ANZSGM

ANZSGM Submission

Response to the Productivity Commission interim report ‘Delivering Quality Care more efficiently’.

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The Australian and New Zealand Society for Geriatric Medicine

The Australian and New Zealand Society for Geriatric Medicine (ANZSGM) is the peak professional body for geriatricians and other medical practitioners who wish to advance equitable access to the highest quality care and foster excellence in health care of older persons in Australia and New Zealand.

We support the needs of geriatricians in Australia and New Zealand to help them provide the best possible care to older people. Our focus is on policy development and education. We advocate to government for improvement and innovation in aged care medical services and for the professional needs of geriatricians. ANZSGM members represent the organisation on committees and advisory groups whose purpose is to shape the future of care for older people across Australia and New Zealand.

We set, promote and continuously improve the standards of clinical practice in geriatrics throughout Australia and New Zealand. The Society is the chief advocacy group for medical specialists in aged care and aims to facilitate training and professional development to improve medical practice to enhance the quality of care for our patients.

ANZSGM response

The Australian and New Zealand Society for Geriatric Medicine (ANZSGM) welcomes the opportunity to provide feedback to the Department of Health, Disability and Ageing on the Productivity Commission report *Delivering Quality Care More Efficiently*.

We commend the report for effectively identifying priority reforms, particularly in the areas of:

- Reforming quality and safety regulation to support a more cohesive care economy;
- Embedding collaborative commissioning to strengthen the integration of care services; and
- Establishing a national framework to guide government investment in prevention.

ANZSGM members have provided feedback on each of the draft recommendations. Overall, we strongly support the direction of the reforms, which align closely with our priorities. In particular, we welcome the proposed prevention framework and the emphasis on collaborative commissioning, which has proven highly effective in our Local Health District. We also recognise the value of consistent regulatory frameworks to underpin quality and safety across the sector.

Draft recommendation 1.1 The Australian Government should pursue greater alignment in quality and safety regulation of the care economy to improve efficiency and outcomes for care users

- A single digital portal and unified standards may reduce duplication, but aged care carries distinct clinical risks compared with NDIS and veterans' services. Any harmonisation must preserve safeguards specific to dementia, delirium, polypharmacy, falls, malnutrition, and elder abuse.

- Worker screening and national registration are strongly supported; however, regulation should also recognise the specialised geriatric expertise required in dementia care, palliative care, and geriatric syndromes. A "generic" approach risks diluting these competencies.

- Caution is needed on the use of artificial intelligence in aged care. Decision-support tools should only complement, not replace, clinical judgment—particularly in frail older populations.

- Alignment of standards and definitions across schemes is generally supported, noting that the Aged Care Quality and Safety Commission already adopts the NDIS definition of

restrictive practices. We also recommend that the NDIS be subject to the same level of independent audit as aged care.

- While consistency in regulation is desirable, there are important differences between NDIS and aged care cohorts. For example, the NDIS model addresses lifelong disability more effectively than progressive neurodegenerative conditions such as dementia. Flexibility in service design and delivery must therefore be maintained.

- Not all carer skills are transferable across sectors. Both aged care and NDIS require workforce expertise tailored to the specific needs of their clients.

Draft recommendation 2.1 Governments should embed collaborative commissioning, with an initial focus on reducing fragmentation in health care to foster innovation, improve care outcomes and generate savings

We strongly support this recommendation, as collaborative commissioning has the potential to deliver better health care and aged care services for older Australians.

- Funding agreements between the Commonwealth and states/territories should continue to evolve to recognise hospital *non-inpatient* activity such as outreach/in-reach services, urgent community care for older people, and telehealth.

- Embedding collaboration between PHNs, LHNs, and ACCHOs is promising. However, older people are often under-represented in commissioning discussions. Mechanisms to ensure geriatric medicine expertise and consumer voices from older people and carers should be mandated.

- Reducing preventable hospitalisations requires targeted geriatric models of care, including Hospital in the Home, Residential In-Reach, ACE (Acute Care of the Elderly) units, and community-based multidisciplinary teams. These are proven high-value commissioning opportunities.
- Data-sharing arrangements should extend beyond hospital activity and costs to include measures such as functional status, cognitive assessments, frailty indices, and advance care planning.

- The collaborative commissioning model between Northern Sydney LHD and Sydney North PHN (Box 2.1 of the Report) demonstrates how such partnerships reduce fragmentation across state/territory and Commonwealth services, enabling timely assessment and management for older people.

- While this recommendation is laudable, it will need to address the persistent challenge of Federal/State divisions of responsibility.

Draft recommendation 3.1 Establish a National Prevention Investment Framework to support investment in prevention, improving outcomes and slowing the escalating growth in government care expenditure

We strongly support the establishment of a National Prevention Investment Framework, recognising its potential to improve outcomes across the lifespan and reduce long-term care expenditure.

- In aged care, prevention must extend beyond lifestyle modification to include secondary and tertiary prevention such as falls prevention, early recognition of cognitive impairment, continence management, nutrition, and medication safety.

- Cost-effectiveness analyses should measure not only hospital savings but also improvements in quality of life, independence, and reduced carer burden.

- There is a strong case for prioritising frailty prevention and reversal programs, which have demonstrated benefits in delaying dependency and institutionalisation.

- Dementia prevention must be a core priority. The 2024 *Lancet Commission on Dementia* estimates that up to 40 per cent of dementia is preventable, with risk factors spanning childhood to older age. Addressing these risk factors also reduces the incidence of frailty and other chronic diseases.

- Only evidence-based prevention programs should be supported, both in their design and delivery. Superficial awareness campaigns (e.g. brief advertising) are insufficient; programs must be structured, sustained, and measurable.

Additional Comments on the Interim Report

- Figure 1 only references CHSP supports; it would be useful to also include HCP supports for completeness.

- Under Recommendation 2, collaboration appears limited to PHNs, LHNs, and ACCHOs. Partnerships with NGOs and other non-government providers are equally important and should be explicitly addressed.

- Collaborative programs should also extend to residential aged care facilities. RACF residents remain part of the community and are significant users of hospital services, yet their needs are underrepresented.

- All collaborative interventions should be evidence-based or subject to rigorous evaluation to confirm both clinical and cost benefits.

- The proposal for a prevention advisory board modelled on PBAC/MSAC is welcome, provided there are safeguards against industry capture ("Big Prevention") and robust transparency around decision-making.

- Reforms must also address rural and regional inequities, where access to geriatric expertise and integrated care is most limited.

- Workforce development in geriatrics requires greater emphasis—not only expanding numbers but also upskilling existing staff in dementia care, delirium recognition, and management of geriatric syndromes.

- A national data repository should collect meaningful quality indicators for older people, such as rates of delirium, falls, pressure injuries, avoidable hospital transfers, and access to palliative care.

Conclusion

In conclusion, ANZSGM strongly supports the overall direction of the Productivity Commission's recommendations, while emphasising the need to preserve safeguards and clinical expertise that are critical to the care of older Australians. Reforms to regulation, commissioning, and prevention frameworks must be tailored to the unique needs of older people, particularly those living with frailty, dementia, and multiple comorbidities. Ensuring collaboration across Commonwealth, state, and local services, supported by robust data and evaluation, will be essential to achieving better outcomes and reducing fragmentation. We look forward to continued engagement with government to ensure these reforms deliver safe, effective, and sustainable care for our ageing population.