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SUBMISSION

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AMA submission to Productivity Commission Interim Report- Delivering Quality Care More Efficiently

Submitted via: https://engage.pc.gov.au/surveys/secure_form/survey/make-your-submission

Introduction

The Australian Medical Association (AMA) strongly supports the streamlining of regulation, collaborative commissioning and a greater national focus on preventative health. The AMA has long called for an increase to the budget spend on prevention. Chronic diseases, preventable hospitalisations, and rising costs threaten health system sustainability. Investing in prevention shifts the focus from treating illness to keeping people well to delivering healthier communities and stronger economic returns. The AMA is also supportive of aligning health services to local population health priorities. However, healthcare professionals alongside consumers and communities must be involved in the decision-making, improving relevance and uptake and reducing duplication. Reforming regulation across the different health sectors will assist in cutting unnecessary red-tape, however there will always remain a need for sector-specific regulations to uphold integrity and optimal service provision. In turn, we have addressed the interim reports' recommendations and information requests.

Draft recommendation 1.1: Reform of quality and safety regulation

The AMA is supportive of harmonised regulation, when co-designed with health professionals, especially doctors who are often the first contact for patients.

The AMA suggests aligning regulation across aged care, National Disability Insurance Scheme (NDIS), and veterans' care to improve efficiency and outcomes. We support the principle that regulatory oversight should be proportionate to the level of risk posed to the public. Professions that present minimal risk do not require the level of statutory oversight that needs to apply to high-risk professions, such as medicine.

It is important to strike a balance between the regulatory status conferred by inclusion in the National Scheme and the actual need for regulation based on public risk. The recent complexity review conducted into the National Scheme, has made recommendations on reforming and improving the regulatory environment, and the AMA notes the recommendation on the suggested three-tier model appears reasonable in principle.

The AMA supports exploring the suitability of a streamlined regulator across the above-mentioned sectors. The AMA would welcome the opportunity to provide further comment when more detail on this proposal is developed should the recommendation be adopted by government.

Information request 1.1

For which care services (across aged care, NDIS and veterans' care and beyond) and performance indicators are there the greatest overlap in quality and safety reporting requirements?

What are some examples of duplicative reporting requirements across sectors? What should a standardised reporting framework for providers look like? Are there examples of cross-sectoral standardised reporting frameworks that have reduced the reporting burden on providers? How could technology be used to support a standardised reporting framework?

What quality information should be publicly reported to support service improvement and innovation?

Aged care and NDIS providers often report similar metrics (e.g. incident reporting, staffing ratios, client outcomes). For example, providers must submit similar audit documentation to multiple regulators (e.g. aged care and NDIS), often with minor formatting differences.

Where 'core indicators' can be identified (i.e. quality and safety incidents such as accidents, reportable safety measures such as hand hygiene, patient or client experience and outcomes and workforce metrics) these should be as standardised as possible. Where sectors differ, these could be reported as 'sector-specific modules'.

Digital interoperability will be essential to support these reporting requirements, and central digital portals should be adopted where possible.

Information request 1.2

What are the costs, benefits and risks of a single quality and safety regulator across aged care, NDIS and veterans' care services?

To what extent would a single regulator produce a more coordinated, consistent and efficient system, especially if regulation was based on a single set of practice and quality standards and a single provider registration and audit system?

How might a single regulator be unable to accommodate differences in services and service users across sectors? What could be the consequences?

A single regulator has the potential to streamline oversight, reduce duplication, as well as provide clearer accountability, better data integration, and improved user navigation.

The risk, however, is the heterogenous nature of the sectors and a single regulator may be prone to overlooking sector-specific requirements, or worse, become so far removed from the end-user (the patient, client or consumer) that a single regulator could lose sight of the individualistic nature of the care sector. While the AMA supports simplification, it will remain important to retain sector-specific inputs and foster co-design opportunities in the design of one regulatory body.

Information request 1.3

What are the potential benefits and costs of aligning regulatory requirements across aged care and NDIS services for the development of behaviour support plans?

What is the scope to align regulatory requirements for the use and authorisation of restrictive practices within NDIS services and across aged care and NDIS services?

While the AMA supports the alignment of regulatory requirements where possible, we also note that these sectors have different training needs and legislative requirements which may be difficult to harmonise. We therefore suggest there is a focus on shared principles (e.g. least restrictive practice, consent, review mechanisms) and harmonise documentation and reporting.

Draft recommendation 2.1: Embed collaborative commissioning

Information request 2.1

What additional factors to establish a consistent joint governance framework should be considered?

How should an outcomes framework be designed to support joint monitoring and reporting? What other factors should be considered for joint monitoring and reporting?

How should LHNs and PHNs partner with ACCHOs and other organisations?

Best medical practice is based on team care and collaboration between organisations to serve the community. ACCHOs provide an excellent collaborative and culturally sensitive healthcare to Aboriginal and Torres Straight Islanders. However, all organisations should be striving to provide best medical practice which is respectful and inclusive. ACCHOs do still require mainstream services to lean in and help uplift specific services and awareness campaigns.

Programs commissioned by PHNs could be greatly improved through better engagement with the GPs and medical services working within the LHNs. The most recent review of PHNs by the Auditor General concluded that PHNs delivery model is not achieving its two objectives: improving the efficiency and effectiveness of health services for people, particularly those at risk of poor health outcomes; and improving the coordination of health services and increasing access and quality support for people. The Auditor General's report provided eight recommendations (seven recommendations were agreed in full by the Department of Health and Aged Care, with one recommendation agreed in principle). The eight recommendations centred on improving transparency, performance measures and public reporting of all PHN efficiencies.

LHNs and PHNs have a unique opportunity to create comprehensive wrap around services with GPs and allied health professionals working under one roof. The AMA is supportive of bolstering investments to develop co-ordinated models of care that are appropriate for the needs of communities and regions. The AMA recommends specific investment in wrap-around services that have the potential to offer better return on investment and health outcomes rather than investing in siloed service delivery models, particularly in rural, regional, and remote areas.

The AMA also recommends that LGBTQIASB+ community-controlled organisations are included as organisations working within the models for collaborative care. This is in line with the AMA's LGBTQIASB+ position statement which notes the importance of supporting LGBTQIASB+ community-led health services to provide targeted, informed and appropriate support for people who are

LGBTQIASB+. The National Action Plan for the Health and Wellbeing of LGBTIQA+ People 2025–2035 also suggests, per action 7, the importance of building capacity and scale of health and wellbeing services for LGBTIQA+ people.

Benchmark reporting must be implemented within every intervention, before funding and scale-up occur. Without rigorous evaluation, cost-effectiveness and the assurance that programs are contributing to reducing preventable hospitalisations and driving future improvements beyond this measure. The AMA suggests there needs to be a focus on co-design with those delivering primary care in the community, including general practitioners.

Information request 2.2

What levels of resourcing are required to: first, support enhanced joint governance requirements; and second, provide sufficient dedicated funding for collaboratively commissioned services?

What types of funding could be pooled to support collaborative commissioning?

How should the funding adjustment be implemented in practice? What unintended consequences could a funding adjustment to incentivise collaborative commissioning have? Are there outcome measures beyond potentially preventable hospitalisations that should be targeted with the incentive?

What are the costs of existing collaborative commissioning programs? Is there other information that could inform estimates of the benefits of collaborative commissioning?

The next addendum to the National Health Reform Agreement should support collaboration between Local Hospital Networks (LHNs), Primary Health Networks (PHNs), Aboriginal Community Controlled Health Organisations (ACCHOs) and LGBTQIASB+ community-controlled organisations, through incentivising team-based care and wrap around services. In the mid-term review of the NHRA 2020-25, the first recommendation was for the next NHRA to be reframed as single collaborative health system Agreement that acknowledges that health system performance is not just the function of the hospital but is also inclusive of primary, disability, aged care and prevention sectors working effectively together in the interests of the consumer. Additionally, the mid-term review called for the establishment of a nationally consistent governance framework with formal governance structures, mechanisms and roles and responsibilities that drive and enforce integration between LHNs, PHNs, and ACCHOs. Underpinning the success will be shared, and where possible, linked datasets on population and service utilisation at the local level. Local health priorities must underpin greater funding and long-term funding. Too many examples exist where a service has been established by a PHN, only for the service to be discontinued due to funding cuts or inability to obtain long-term and recurrent funding. The AMA supports:

- the proposed joint governance arrangements to support collaboration
- the inclusion in ACCHOs to inform planning and shared decision making.

Draft recommendation 3.1 Establish a National Prevention Investment Framework

The AMA supports the establishment of an independent, evidence-based and equity-focused National Prevention Investment Framework. Prevention is a cornerstone of sustainable, high-quality care and must be embedded in long-term government strategy. Bipartisan support will be required to ensure

long-term viability of the investment framework. Underpinning the framework, must be the Australian Government National Preventive Health Strategy. During the consultation on the strategy, AMA provided a submission outlining several areas for improvement, including the need to:

- translate recognition of underlying health determinants into practical policy actions
- acknowledge climate change mitigation as a key preventive health opportunity
- ensure all targets are measurable and time-bound
- provide greater detail on implementation plans and accountability mechanisms.

The AMA also supported the allocation of 5 per cent of health funding to prevention by 2030, and called on the government to implement a tax on sugar-sweetened beverages and a volumetric tax on alcohol to generate revenue for increased prevention funding.

Many of these suggestions remain relevant to the work suggested by PC regarding the National Preventive Investment Framework, and we welcome further consultation and offers its expertise to support implementation of a Framework.

Information request 3.1

When prioritising different proposals, how should factors such as overall net benefits, net fiscal effects, cost-effectiveness, equity, ease of implementation, timescale and the value of future benefits and costs be weighted?

The AMA supports a balanced, transparent, and evidence-informed approach to prioritising prevention proposals. The following criteria should be weighted as follows:

- **Equity (high priority):** Equity must be a core consideration. Proposals must address health disparities, particularly for Aboriginal and Torres Strait Islander peoples, rural and remote populations, and socioeconomically disadvantaged groups. Preventive health is not only economically sound—it is foundational to a healthier, fairer society. The AMA recognises that health outcomes are shaped by more than clinical care; they are deeply influenced by the determinants of health in which people are born, grow, live and work under, as per our position statement on Social Determinants of Health.
- **Overall net benefits (high priority):** Proposals should demonstrate clear, quantifiable improvements in health outcomes, wellbeing, and productivity. This includes both direct and indirect benefits to individuals and communities.
- **Cost-effectiveness (high priority):** Programs must deliver value for money. Interventions that are cost-saving or highly cost-effective should be prioritised, especially when targeting high-burden conditions.
- **Net fiscal effects (moderate to high priority):** Fiscal sustainability is critical. Proposals should show potential to reduce long-term government expenditure, particularly in acute care, while recognising that some benefits may accrue beyond the forward estimates.
- **Value of future benefits and costs (moderate to high priority):** Future benefits must be appropriately discounted but not undervalued. Actuarial modelling and linked administrative data should be used to estimate long-term impacts.
- **Ease of implementation (moderate priority):** Feasibility, including workforce capacity, infrastructure, and regulatory alignment, should be considered, but should not override the potential for long-term impact.
- **Timescale of benefits (moderate priority):** While short-term gains are valuable, proposals with long-term benefits should not be disadvantaged. A diversified portfolio approach can balance immediate and future returns.

Are there existing frameworks that do this well?

The AMA acknowledges several frameworks that provide useful models:

- **Victorian Early Intervention Investment Framework (EIIF):** Offers a cross-sectoral, outcomes-based funding model with long-term evaluation. However, transparency and methodological rigour must be strengthened.
- **Washington State Institute for Public Policy (WSIPP):** Provides robust cost-benefit analysis and ideas around how best to conduct long-term modelling which is needed for preventive health evidence gathering. Adaptation to Australian contexts and within Australian health and departmental systems would be needed.
- **Pharmaceutical Benefits Advisory Committee (PBAC) and Medical Services Advisory Committee (MSAC):** These bodies demonstrate a rigorous, transparent, and independent assessment processes that could inform the governance of a Prevention Framework Advisory Board.

Should there be minimum cost-effectiveness and/or cost-benefit ratios and how should they be set?

The AMA supports establishing indicative thresholds for cost-effectiveness and cost-benefit ratios, so long as there is flexibility to accommodate equity and strategic priorities. Cost effectiveness thresholds should be consistent with international benchmarks. Exceptions for both cost-effectiveness and cost-benefit ratios may be warranted for equity-focused programs or those with strong qualitative evidence. Thresholds should be reviewed periodically and adjusted based on evolving evidence and where fiscal conditions improve, warranting more economic freedom for spending in preventive health.

How should decision makers balance the need to assess early effectiveness of programs with the need to maintain consistent long-term funding for programs with long-term benefits?

The AMA recommends a tiered evaluation approach that prioritises stability of program funding, and accountability through evaluation of programs:

- **Funding stability**: Multi-year funding agreements (minimum five years) should be standard for prevention programs, with conditional renewal based on performance. Maintain funding for programs with strong theoretical and empirical foundations, even if long-term outcomes are pending.
- **Evaluation funding**: Allocate a fixed proportion of program budgets (e.g. 5–10 per cent) to rigorous evaluation, including randomised trials where feasible and pragmatic observational studies were not. Use early process and intermediate outcome measures to assess program trajectory (e.g. increased screening rates, reduced risk factors).

How could a diversification strategy be designed to ensure that prevention programs from different sectors and with benefits across different timeframes are funded?

A national diversification strategy should look to balance four key considerations:

- **Equity lens**: Ensure representation of programs targeting priority populations and regions.
- **Portfolio design**: Include programs across sectors (health, education, justice, environment and housing) and timeframes (short-, medium-, and long-term).

- **Risk balancing**: Combine high-certainty, short-term interventions with innovative, long-term programs that may carry greater uncertainty but offer transformative potential.
- **Governance**: The Prevention Framework Advisory Board (PFAB), with diverse representation in membership, should oversee portfolio composition, monitor balance, and recommend adjustments. The PFAB must be independent and not made reliant on any single term of government for continuation.

Information request 3.2

How should a National Prevention Investment Framework be implemented?

The AMA supports the establishment of a National Prevention Investment Framework as a critical reform to improve health outcomes and reduce long-term care expenditure. Implementation should be guided by the following principles:

- **Independent governance**: Establish a cross-sectoral Prevention Framework Advisory Board (PFAB) to assess funding proposals, develop standardised actuarial models, and oversee evaluation processes.
- **Evidence-based assessment**: Use cost-benefit and cost-effectiveness analysis to prioritise programs that deliver measurable outcomes and long-term fiscal benefits.
- **Integrated funding mechanism**: Create a National Prevention Investment Fund or modify existing budget processes to allow for multi-year funding and co-contributions from state and territory governments. Funding must not be beholden to a single term of government.
- **Legislative and intergovernmental agreements**: Formalise roles and responsibilities through an intergovernmental agreement and federation funding schedules to ensure accountability and continuity.
- **Evaluation and transparency**: Require rigorous evaluation and public reporting of outcomes to build the evidence base and maintain public trust through processes that show accountability and commitment to the cause of preventive health.

This approach aligns with AMA policy advocating for sustainable investment in preventive health, recognising the cross-sectoral benefits and long-term value of prevention.

What is the best way to incentivise Australian, state and territory governments to invest in prevention to improve future outcomes and avoid future costs?

To incentivise investment across jurisdictions, the framework should:

- **Maintain existing funding commitments**: Require governments to sustain current prevention programs to avoid cost-shifting and ensure continuity of care.
- **Introduce outcome-based funding adjustments**: Link funding to achievement of shared outcomes, such as reductions in potentially preventable hospitalisations (PPHs), to reward effective collaboration.
- **Recognise shared benefits**: Use actuarial modelling to estimate the proportional benefits accruing to each level of government, enabling fair co-funding arrangements and early buy-in from all levels of government.
- **Enable second-round fiscal effects**: Adjust budget rules to account for long-term savings and cross-portfolio impacts, encouraging investment in programs with delayed but significant returns.

These mechanisms are also reflective of the AMA's commitment to collaborative, outcomes-focused health policy that supports long-term system sustainability.

What changes if any to the existing budget operational rules would be needed to support consideration of recommendations from the Prevention Framework Advisory Board (PFAB)?

To support PFAB recommendations, changes to budget operational rules are required. These must include dedicated budget pathways that establish a stream or fund for prevention proposals assessed by PFAB, with multi-year funding commitments. These pathways must be backed up by appropriate reporting, possibly as a preventive investment statement in budget papers. These papers could consider including reference to the fiscal costs of inaction; however, this reporting may be best done as an annual report under the PFAB.

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

Yes, the AMA believes alternative governance approaches should be considered to enhance flexibility and accountability:

- **Institutional setting**: the PFAB should be independent but embedded within a broader national health governance structure, such as potentially the Australian Centre for Disease Control, to ensure cross-sectoral coordination.
- **Co-funding processes**: Develop a formula-based approach to co-funding, based on economic estimates of benefit distribution, with flexibility for regional variations across different jurisdictions. This formula should also consider work that jurisdictions are already doing to progress preventive health initiatives.
- **Evidence requirements**: Tailor evaluation standards to program scale and risk, allowing for pragmatic approaches where randomised trials are not feasible, and where preventive health initiatives may take longer to provide evidence of success. Preventive health outcomes do not fit election cycles easily, so must be funded past single government promises.

The AMA maintains a strong position on the need for transparent, accountable and evidence-informed health governance, especially where new frameworks are being founded.

What considerations would ensure that the framework works together with existing prevention programs funded by states and territories?

To ensure alignment with existing programs three key considerations must be made in forming the framework:

- **Mapping and integration**: Conduct a national audit of current prevention initiatives at the beginning of initiating the framework, to identify overlaps, gaps and opportunities for integration.
- **Continuity of funding**: Require maintenance of existing effective programs as a condition of participation in the framework, many of the programs that would value from a preventive health framework already exist and just need better support and long-term commitment. This framework should be about streamlining and supporting programs, not re-inventing the wheel.

- **Data sharing agreements**: Facilitate access to linked administrative datasets to support evaluation and coordination across jurisdictions, this data must be across departments and jurisdictions to break down data-siloing and ineffective reporting.

These considerations ensure the framework complements existing efforts and supports coordinated equitable access to preventive care.

How can the framework encourage governments to keep supporting existing effective prevention programs?

To encourage governments to support existing prevention programs, and better support instead of 'reinventing the wheel' on prevention, the framework should:

- **Incentivise continuity**: Make ongoing funding contingent on performance and evaluation outcomes, with PFAB recommending continuation or scaling of effective programs. This approach aligns with AMA's advocacy for sustained investment in proven health interventions.
- **Public accountability**: Require transparent reporting on program outcomes and funding decisions to maintain public and political support.
- **Embed in agreements**: Include clauses in intergovernmental agreements committing parties to sustaining effective programs and avoiding duplication. This must include agreements across areas of government policy that are often soiled such as health, justice, environment, housing, education and social services.

Conclusion

The AMA broadly supports the draft recommendations of the interim report. We strongly support the establishment of a National Prevention Investment Framework as a transformative reform to improve health outcomes, reduce future costs, and enhance system efficiency. Implementation must be underpinned by independent governance, robust evaluation, and collaborative funding arrangements that reflect the shared benefits of prevention across governments and sectors.

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