Delivering Quality Care More Efficiently: Productivity Commission Interim Report

Submission from The George Institute for Global Health
September 2025

Prof. David Peiris
Chief Scientist
The George Institute for Global Health

Prof. Stephen Jan
Director, Health Systems Science
The George Institute for Global Health

Ms Veronica Le Nevez
Head of Impact and Engagement, Australia
The George Institute for Global Health

Acknowledgement of Country

The George Institute for Global Health acknowledges the traditional owners of the lands on which we work, and in particular the Gadigal and Bidjigal people of the Eora Nation on which our Sydney office is situated. We pay our respects to Elders past, present and future.

We value and respect the ongoing connection of Aboriginal and Torres Strait Islander peoples to Country, and are committed to working in partnership with communities to deliver better health outcomes.

Executive Summary

The George Institute welcomes the Productivity Commission's Interim Report: *Delivering Quality Care More Efficiently*.

We strongly support the draft recommendations:

- 2.1 to embed collaborative commissioning, to reduce fragmentation in health care and foster innovation, improve care outcomes and generate savings; and
- 3.1 to establish a National Prevention Investment Framework, supported by an independent Prevention Framework Advisory Board and an intergovernmental agreement to establish cross-jurisdictional funding mechanisms and roles and responsibilities for implementation.

Our research and the extant literature highlights that key success factors for collaborative commissioning include:

- Strong trust-based relationships formalised through boards or joint commissioning bodies to ensure continuity and accountability;
- A clear value proposition for primary care practitioners, patients and consumers to overcome system inertia and encourage innovation and wider adoption;
- Integration of consumers and communities into decision making to ensure alignment with community needs;
- a broad outcomes framework that includes quality of care, patient experience and process measures, alongside utilisation metrics.

On prevention, we identify the following key factors as important for establishing an effective national prevention framework:

- the Prevention Framework should be broader than investment to discourage a overly program-focused approach. As noted in previous submissions, other policy

tools including regulation, restrictions on advertising of unhealthy products, and education campaigns;

- The Prevention Investment Advisory Board should be enabled by legislation to ensure that it has the necessary authority and independence to be effective;
- The Prevention Investment Advisory Board should be accompanied by a requirement for independent health impact assessments as part of the cabinet submission process to address social and other determinants of health across portfolios.
- We support the development of an intergovernmental agreement on prevention, and note that it can be augmented by other fiscal measures such as a sugar sweetened-beverage tax, similar to other health taxes that have been successful in raising revenue for health and social care.

1. Collaborative Commissioning

The George Institute strongly supports **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 commend the Commission's recognition of collaborative commissioning as a mechanism to reduce fragmentation and improve care integration. Our experience evaluating seven Patient-Centred Co-Commissioning Groups (PCCGs) in NSW over the past four years provides several insights that we believe can strengthen the Commission's recommendations.

a. Governance Reform

We strongly support the emphasis on governance reform. Our forthcoming evaluations show that successful collaborative commissioning is underpinned by strong, trust-based relationships—particularly at the executive level of Local Health Districts (LHDs) and Primary Health Networks (PHNs). However, reliance on goodwill alone is insufficient in an environment where there are competing priorities that can divert resources and attention. We recommend the Commission consider more formal governance mechanisms, such as legally constituted joint entities or joint boards, to ensure continuity and accountability beyond individual relationships.

Examples of a similar approach are the Accountable Care Organizations (ACOs) established under the U.S. Affordable Care Act 2010[i], and Integrated Care Systems in the

UK[ii]. ACOs bring together a network of care providers to support both publicly funded and private health care programs in the U.S to receive coordinated, multidisciplinary care. The organisations are typically governed by a Board of Directors that includes representatives of the participating organisations, including hospitals, health services, primary care providers, other health professionals and consumers.

Each ACO has a management structure that includes a medical director responsible for clinical leadership. Through this model of care, efficiencies are often generated: in 2022 ACOs generated US$1.8 billion in savings to the Medicare program, and serviced 11 million Medicare recipients through 500 ACOs.

In England, there are currently 42 Integrated Care Systems established under the UK Health and Care Act 2022[iii]. Integrated Care Boards are established as a statutory NHS body accountable to NHS England and the UK Parliament. It can include representatives from NHS providers, primary care, and local authorities as well as patient and community voices. Integrated Care Partnerships are statutory joint committees between the Integrated Care Board and local authorities, which can include a broader range of health and social care including for example housing, education and justice services. Outcomes include:

- Reductions in unplanned hospital visits (for example Somerset Complex Care Team)
- Reduced ambulance call outs and hospital stays (for example Derbyshire Integrated Neighbourhood Team)
- Greater access to child and adolescent mental health services, and social services, improving employment outcomes (Working Together to Improve Health in Fleetwood).

In Australia, more holistic care that includes integrated health and social care is delivered through a culturally safe and community-controlled governance model through Aboriginal Community Controlled Health Organisations (ACCHOs). Each ACCHO is governed by a Board, and commissions the health services that communities need across a range of disciplines including primary, specialist and allied health services, while incorporating wider determinants of health such as housing, employment and education. However, ACCHOs differ from other integrated care models in that the Board is comprised of elected community members, and services are delivered by staff or contracted providers. ACCHOs are funded through blended payments incorporating Commonwealth block funding; eligibility to bill under the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme; targeted funding from State governments for particular programs; philanthropy and partnerships with Primary Health Networks.

This limited set of examples highlights the complexity of health systems which is both a reason for establishing collaborative commissioning, and a potential barrier to its success. The examples provided are successful governance models that can inform the design of collaborative commissioning arrangements, but no one model is appropriate for all contexts. Rather than creating another layer of decision making, thoughtfully designed collaborative commissioning arrangements can serve to simplify and streamline decision making in a complex network of funders and service providers.

b. Service Delivery Innovation

The interim report could be strengthened by greater attention to what services are actually commissioned. Our research highlights that the perceived value of commissioned services by general practitioners and communities is critical to uptake and success (forthcoming). For example, a geriatrician-to-GP hotline in Northern Sydney Local Health District was widely praised and led to increased engagement, while a cardiology pathway in Western Sydney had lower levels of adoption as the perceived value to care providers was less compelling. The purpose and value of the service to both clinicians and patients needs to be clearly articulated to drive engagement and trust in the service. New models of care involve organisational change and require innovation, detailed behaviour change strategies and appropriate system level supports . Attempts to implement a new model of care must be easy to understand and 'low-friction' to encourage continued use and change of existing processes. We urge the Commission to: (1) emphasise the importance of carefully co-designing services that meet identified needs ; (2) foster a culture of innovation in testing newly commissioned services to build a knowledge base of successful and failed commissioning: and (3) wherever possible streamline and improve on existing processes that can support adoption at scale.

c. Consumer and Community Engagement

Community perspectives are largely absent in current collaborative commissioning models. We recommend that future frameworks explicitly incorporate mechanisms for community input and feedback, ensuring that services are not only clinically effective but also perceived as valuable by those they serve. Taking the lead from ACCHOs, community engagement is achieved through the composition of the governing Board which is elected by the community, ensuring strong linkages between community needs and the design and delivery of services. At the very least, consumer and community representatives need to be included in the governance of collaborative commissioning groups as full voting members to ensure that communities are represented at the highest level of decision making.

Navigating health care is complex and consumers often don't know what services are available or how to access them. It is important therefore that improved consumer

experience is considered a performance objective in service design and delivery to maximise the utility of new services to consumers and ensure that services are optimally utilised.

d. Incentives and Funding

We agree that barriers to pooling funding or other forms of joint commissioning should be removed, and funding for PHNs and LHNs made more flexible. We support the Commission's call for dedicated funding and outcome-based payments. However, we caution that the proposed 10% reduction in potentially preventable hospitalisations (PPHs) may be overly ambitious in the short term. International evidence suggests more modest gains (1–2%) are typical in early years[iv].

Utilisation metrics also oversimply a complex system. The delivery of new services and models of care may relieve currently unmet demand, resulting in new services being fully utilised but delivering lower reductions in PPH than anticipated. Viewing the benefits of collaborative commissioning solely through the lens of hospital utilisation misses other key benefits, including improved access and quality of care, improved consumer experiences and improved health outcomes and services that more adequately address social determinants of health such as housing, health and employment. We therefore recommend a broader outcomes framework that includes quality of care, patient experience and process measures, alongside utilisation metrics.

We also recommend system planners take a long-term perspective on developing reforms in this area and set realistic expectations on the efficiency gains that may be made. Narrowly conceiving Collaborative Commissioning as a hospital avoidance intervention that will achieve outcomes within the short-term undervalues the potential of such a reform to promote a high performing health system on multiple dimensions.

2. Preventive Health

The George Institute strongly supports **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.**

This proposal provides an important first step in addressing the problem of chronic underinvestment in prevention in Australia. In prevention, potential programs that save lives, improve wellbeing and avert hospitalisations often do not get funded because there is no clear pathway to investment and a lack of agreement on the roles and responsibilities of the Commonwealth, States and Territories. In contrast, if a new drug, medical device or treatment is developed that will save lives and is cost-effective, we can be reasonably

assured that it will be available to the Australian population is a relatively short space of time.

It is also important to take a wider approach to prevention than investing in particular programs or interventions. As highlighted in previous submissions, successful public health prevention programs can include a wide range of policy tools, including regulation and restrictions on advertising unhealthy products.

In response to Information requests 3.1 and 3.2, there are some guiding principles that may assist in developing an effective prevention investment framework:

- **Equity should be central to all policy making** to ensure that those who are hardest to reach – whether due to geography, language and cultural barriers, systemic disadvantage or other barriers – are prioritised. It is important to recognise that addressing equity may require investing more per unit of service delivered to achieve similar outcomes; but if equity is not prioritised it is unlikely that important goals such as closing the gap between health outcomes for Indigenous people and non-Indigenous people will be achieved.
- **Monitoring and evaluation should be planned from program inception** so that data is collected throughout and can inform policy and program development and adaptation.
- **Existing decision rules can provide a useful starting point**; for example PBAC's threshold of approximately $50,000 per Quality Adjusted Life Year (QALY), and the Treasury's statistical life year value of $222,000 per person for life saving interventions. However, decision rules need to be carefully considered to ensure good alignment with policy objectives.
- **Minimum cost-effectiveness/cost-benefit ratios**: as the ACE- Obesity Policy study[v] and WHO Best Buys for Prevention[vi] demonstrate, prevention initiatives are highly cost-effective and therefore there should not be a need to create new or different measures for assessing the cost-effectiveness of prevention initiatives. However, it is important to consider the full range of benefits that prevention initiatives can provide, including where they accrue outside the health system.

We strongly support the three components of the recommendation as outlined and provide further comments on each below.

a. An independent Prevention Framework Advisory Board

An independent Prevention Framework Advisory Board would set out a policy pathway to facilitate investment in prevention interventions in Australia. This would involve individual prevention programs being assessed as candidates for funding through a process akin to

the health technology assessment framework applied generally to new medicines and health care programs in Australia.

The framework should be informed by and build on the existing evidence base

We recommend that the Prevention Board prioritise a stocktake of existing evidence-based prevention interventions to identify those that can be immediately rolled out to efficiently target 'low hanging fruit' or 'quick wins'. The WHO best buys for prevention[vi] provides a comprehensive and up-to-date set of prevention interventions that have been categorised based on cost-effectiveness. The ACE-Obesity Policy study[v] assessed the cost-effectiveness of a suite of obesity policy interventions in Australia, providing more local context for diet-related disease.

The Framework should include adequate consultation and engagement to ensure that potential benefits and impacts of prevention initiatives on different populations and subpopulations are appropriately considered.

The framework should be enabled and supported by legislation to ensure it has sufficient authority to be effective

The rationale for similar bodies such as the Pharmaceutical Benefits Advisory Committee (PBAC) and Medical Services Advisory Committee (MSAC) is that they provide independent, rigorous analysis of the evidence to support policy recommendations to government, mitigating interest group pressure and reducing the politicisation of policymaking. If we are to translate the success of PBAC and MSAC to prevention (where arguably interest group pressure has an event stronger influence), the framework needs to have legislative backing to be effective.

An important challenge will be to explain how this initiative will be protected from changes in the political cycle. Part of the answer will be the regulatory and legislative backing that will institutionalise this process. The legislation should define a clear and predictable process to minimise unnecessary challenge and delay.

Addressing determinants of health through health impact assessments on major government initiatives.

There is extensive evidence of the role of social, environmental, commercial, cultural and other determinants of health. For example, poverty, poor quality housing, unemployment, unhealthy food environments, racism and environmental degradation exacerbate poor health and lead to inequities in health outcomes between population groups. Policies implemented by other parts of government can therefore have significant impacts – positive and negative – on health outcomes.

Impacts on health should be considered in major government decisions. This could be done by including the requirement for health impact assessment within the cabinet submission process to ensure that new policies and proposals consider health impacts. This is another tool for promoting prevention that should be included in the Prevention Framework, alongside the Advisory Board.

b. A funding mechanism supporting co-contributions from state and territory governments

The George Institute supports co-contributions from the Commonwealth, State and Territory governments to fund prevention initiatives. This ensures that all jurisdictions have a stake in prevention initiatives and provides a mechanism for supportive engagement and program delivery.

Funding could also be supplemented through other fiscal initiatives, including revenues from hypothecated levies (such as a sugar-sweetened beverage tax) and increased taxation on alcohol.

States and territories can also encourage healthy environments through value capture levies on urban development to fund active transport, green spaces and social infrastructure such as libraries and community spaces.

c. An intergovernmental agreement that outlines prevention funding arrangements and the roles and responsibilities of relevant parties, accompanied by federation funding agreement schedules that deliver Australian Government funding for specific interventions

We welcome the proposal for an intergovernmental agreement, noting that this is aligned with the Huxtable Mid-Term Review of the National Health Reform Agreement, which we have previously supported.

Alongside efforts to create dedicated intergovernmental resourcing for prevention, it is important to recognise that significant progress has been made in states and territories on collaborative, community-centred prevention initiatives.

South Australia (Preventive Health SA), Victoria (VicHealth), Queensland (Health and Wellbeing Queensland) and Western Australia (Healthway) have all established dedicated health promotion agencies with prevention as a key outcome. While resourcing for these

agencies represents a tiny fraction of state health budgets, dedicated resourcing that is separated to some extent from the health portfolio budget provides a measure of protection from diversion of resources to acute care.

NSW offers a range of prevention programs under the *Healthy Eating, Active Living Strategy 2022-2032* operated by the NSW Department of Health, and Tasmania is developing a 20 year preventive health strategy.

State and territory initiatives demonstrate commitment and support amongst jurisdictions to prevention programs and initiatives that could potentially be scaled up with improved coordination and funding at the national level.

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[i] Sax Institute, 2018, *Evidence check: Accountable Care Organisations: an Evidence Check rapid review brokered by the Sax Institute for the NSW Agency for Clinical Innovation,* https://www.saxinstitute.org.au/wp-content/uploads/Accountable-care-organisations.pdf

[ii] NHS England, 2025, *What are integrated care systems?,* https://www.england.nhs.uk/integratedcare/what-is-integrated-care/

[iii] UK Health and Care Act 2022, Health and Care Act 2022

[iv] Sax Institute, 2018, *Evidence check: Accountable Care Organisations: an Evidence Check rapid review brokered by the Sax Institute for the NSW Agency for Clinical Innovation,* https://www.saxinstitute.org.au/wp-content/uploads/Accountable-care-organisations.pdf

[v] Ananthapavan J, Sacks G, Brown V, Moodie M, Nguyen P, Veerman L, Mantilla Herrera AM, Lal A, Peeters A, Carter R. Priority-setting for obesity prevention-The Assessing Cost-Effectiveness of obesity prevention policies in Australia (ACE-Obesity Policy) study. PLoS One. 2020 Jun 19;15(6):e0234804. doi: 10.1371/journal.pone.0234804. PMID: 32559212; PMCID: PMC7304600. Priority-setting for obesity prevention-The Assessing Cost-Effectiveness of obesity prevention policies in Australia (ACE-Obesity Policy) study - PubMed

[vi] World Health Organisation, 2024, *Tackling NCDs: best buys and other recommended interventions for the prevention and control of noncommunicable diseases, second edition*. Geneva: World Health Organization; 2024. Licence: CC BY-NC-SA 3.0 IGO **Tackling NCDs: best buys and other recommended interventions for the prevention and control of noncommunicable diseases, 2nd ed**