

15 September 2025

Inquiry into delivering quality care more efficiently
Productivity Commission
By online submission

Sydney
Level 22/45 Clarence St
Sydney NSW 2000
Australia
+61 2 9249 2900

Melbourne
Level 27/459 Collins St
Melbourne VIC 3000
Australia
+61 3 9658 2300

Wellington
Level 6/22 The Terrace
Wellington 6011
New Zealand
+64 4 974 5565

Submission to inquiry - Delivering quality care more efficiently (interim report)

1 Introduction

We are pleased at the opportunity to provide feedback to the Productivity Commission's Interim Report "Delivering Quality Care More Efficiently."

Taylor Fry has significant experience in developing funding and pricing models for care sector services, as well as evaluation and investment planning across the broad range of government services. We have worked extensively on the types of microsimulation models most commonly used for investment-approach and prevention models, including significant model builds for the Commonwealth, NSW, Victoria and New Zealand. We also undertake evaluations, with a focus on quantitative outcomes and linked data. Our specialist Health Analytics practice focuses on health and aged care system funding and pricing, giving us a unique view of the care sector's funding flows.

Our feedback provides suggestions to enable successful implementation of the Commission's recommendations through maximising the use of data and modelling, particularly relating to Recommendation 2: Embed Collaborative Commissioning and Recommendation 3: A national prevention investment framework.

2 Collaborative Commissioning

We support the need for collaborative commissioning and localised, collaborative planning and needs assessment, particularly to enable investment in public health, reduction in preventable hospitalisations, and developing innovative hospital diversion programs.

Information Request 2.3

Are additional supporting actions by governments needed? How can state and territory governments support and lead change?

The Interim Report has identified significant challenges to data availability and sharing across organisations – this presents a roadblock to identifying need and evaluating impact of commissioned services. In many instances, creating localised data sharing arrangements is not feasible due to the time and investment required, and would create duplication of effort.

A national data infrastructure to support local decision making can be facilitated through existing avenues. For example, the Independent Health and Aged Care Pricing Authority (IHACPA) are already well-placed to manage such datasets and have the infrastructure and consultation processes to collect data and provide jurisdictions with national benchmarking and granular reporting of current and projected costs of care – their existing hospital activity and costs data holding could be expanded to include linked Commonwealth Medicare Benefits Schedule payments and other Primary Health Network (PHN) data, to provide a better view of the full cost to the health system of each healthcare journey.

Such a data set would combine primary care (through MBS, PHNs and other sources) with hospital service use and costs, and could be used by LHNs and PHNs jointly to determine localised need, identify variation in care costs after considering all modes of care, identify unmet need and service gaps relative to other geographic areas, and identify budgets for joint commissioning through visibility of the patient journey across hospitals and primary care – as well as other government services.

National support for the development of innovative local funding and pricing models can also be provided to LHNs and PHNs by IHACPA. The complete cost of care view would also enable IHACPA to determine innovative pricing structures for broader service bundles – encouraging and enabling local collaborative commissioning initiatives through the implementation of the National Health Reform Agreement (NHRA).

3 A National Prevention Investment Framework

Through our work in developing microsimulation models and undertaking extensive linked-data program evaluations across a range of government sectors, we are firm believers that effective early intervention and prevention is good policy; and that there are many opportunities missed because evidence is slow to emerge, or benefits might accrue to different departments and tiers of government. We therefore support the idea of a National Prevention Investment Framework.

Information Request 3.1

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

- **Broadening of prevention considerations** – We support the expansion of what has typically been considered under the prevention umbrella to a broader definition in the Interim Report, as it captures expansion in two different dimensions: the inclusion of both health and social factors and outcomes, and consideration of tertiary prevention, in particular stymying progression of existing conditions.
- **Enabling tertiary prevention** – To date, Australia's large-scale health prevention initiatives have focussed on primary or secondary prevention under the umbrella of Public Health: e.g. initiatives such as tobacco control, skin cancer prevention, and early detection and diagnosis of breast, cervical, bowel, and most recently, lung cancer. However, as almost half of all preventable hospitalisations are related to chronic conditions¹, and an estimated 15.4 million (61%) were living with at least one of the AIHW's selected long-term health conditions² now is the time for an **increased focus on tertiary prevention**, to prevent adverse events for people already diagnosed with chronic conditions.

Tertiary prevention can include both **timely treatment** outside of hospital to prevent hospitalisation, and **diversion to out-of-hospital programs**. An example of a successful hospital diversion program that prevents hospitalisations for complex patients is Sydney Local Health District's Wound Care

¹ National Preventive Health Strategy 2021-2030

² In 2022, AIHW, <https://www.aihw.gov.au/reports/australias-health/chronic-conditions>

Command Centre™ for chronic wound care - our evaluation found that in its first year of operation, the diversion program saved the district over \$1.7M, for a cohort of around 150 patients.³

A national view can also be helpful to identify where hospitalisation is systematically being used as a fall-back option due to unavailability or lack of streamlined connection with other services, such as residential aged care services for older hospital patients who cannot be safely discharged home⁴.

While collaborative commissioning, as recommended by the Interim Report, can support local initiatives, a national framework and microsimulation infrastructure can successfully support identifying cohorts at a national level who would benefit from such programs, as well as estimating intervention budgets and streamlining the evaluation and scalability of programs.

To support tertiary prevention further, we recommend allocating budgets and work programs across the different prevention stages.

Information request 3.2

How should a National Prevention Investment Framework be implemented? What is the best way to incentivise Australian, state and territory governments to invest in prevention to improve future outcomes and avoid future costs?

We comment on factors we believe relevant to a successful framework:

- **There are benefits of basing framework ownership in, or close to, a central agency** – Because central agencies have a view across government departments, they are best placed to assess and fund initiatives that suffer from the ‘wrong pocket problem’. The Victorian Early Intervention Investment Framework takes this approach, and funding bids are assessed at the Department of Treasury and Finance, with a whole-of-government lens. We think a funding mechanism should be tightly integrated with a central agency, as it is more likely to result in a virtuous circle of further investment in prevention as programs prove their value.

In saying this, we note:

- We are not saying central agencies are best placed to determine what prevention activity is pursued independent of other Departments and agencies; rather they are best placed to consistently assess cross-government and cross-time benefits.
 - Ownership of the framework does not necessarily mean ownership of the tools, such as investment microsimulation models (discussed below); often modelling work is best housed at a relevant department or agency. In either case, tools need to be made available so that different departments can use such tools consistently to understand cross-agency and long-term outcomes.
- **There is instructive existing activity across government** – We recognise that there are existing efforts across government to tackle issues of early intervention and the wrong pocket problem, including the examples you highlight in the interim report. For example, the significant work in the social impact investing (SII) space takes a rigorous approach to measurement and typically tackles problems where early intervention leads to significant downstream benefits:

³ Barakat-Johnson et al., Digitising wound care: a cost-consequence analysis of the Wound Care Command Centre™ in Australia. BMC Health Serv Res 25, 873 (2025). <https://doi.org/10.1186/s12913-025-12969-2>

⁴ A. Cohen and V. Tu, Older patients awaiting aged care services – trends from Australian public hospitals, IHACPA2025 conference presentation.

- All state and territory jurisdictions have tried social impact investments, including Social Impact Bonds, as ways to intervene in areas with strong downstream benefits.⁵
- The Department of Social Services has funded social impact investments, including some State and Territory Partnership Trials and several Payment by Outcome (PBO) trials. For example, DSS part-funds the NSW Opportunity Pathways program, which seeks to improve employment outcomes for people in social housing; this leads to fiscal benefits for both State and Commonwealth.⁶ And the White Box PBO trial in disability employment shows strong economic returns compared to the status quo.⁷
- There has been a relatively recent taskforce, managed by the Department of the Prime Minister and Cabinet, to explore the government's role in social impact investing.⁸ This included significant consultation on SII mechanisms.

We would encourage learning from this existing activity for the development of a new framework.

- **Microsimulation models are well placed to support a framework** – The report highlights several investment approach models, which are often supported by underlying microsimulation models. We are fans of such models, as they can give long-term, person-centred and cross-agency views to support initiatives. A clear connection between a model and its uses (for example, modelling the expected benefits from interventions on different cohorts via a scenario tool running on top of the model) will ensure a model provides value. Some considerations:
 - *Incremental approaches and prototype models can be helpful* – Many of the models have built up over time, focusing first on areas where early intervention and prevention are most needed. Such an approach creates the opportunity for quick wins.

Example case study: Improved Diabetes care

Diabetes prevention would be a suitable candidate as the fastest growing chronic condition in Australia, increasing at a faster rate than heart disease or cancer⁹. The disease has significant social and regional variation in prevalence. We understand Diabetes Australia is currently beginning to scope the developing of a Cost of Diabetes model – this model can be developed into a broad microsimulation with future projections and a prevention focus. A diabetes-focussed model should capture:

- Regional and social determinants of developing Diabetes, as well as time to and stage at diagnosis for different socio-economic groups
- The combined cost of care for patients with diabetes, including the cost of primary treatment, and additional treatment costs when patients present with Diabetes as a comorbidity.
- Regional and social determinants of Diabetes treatment modes and health outcomes, after accounting for time to and stage at diagnosis.
- The impact on broader government service and benefit utilisation after diagnosis and after adverse events, such as preventable hospitalisation or the development of a chronic wound.

⁵ See for example, the NDS Office of Social Impact Investment, <https://www.nsw.gov.au/departments-and-agencies/osii/social-impact-investments>

⁶ Its precursor program had a 1.4 benefit to cost ratio, seen in the *Social Housing Service Improvement Initiatives Outcomes and Economic Evaluation Final Report* at [Future Directions for Social Housing in NSW Evaluation | Communities and Justice](https://www.futuredirectionsforhousing.com.au/evaluation/communities-and-justice)

⁷ <https://whiteboxenterprises.com.au/innovate/payment-by-outcomes-trial/>

⁸ <https://www.pmc.gov.au/domestic-policy/social-impact-investing-taskforce>

⁹ Diabetes Australia, <https://www.diabetesaustralia.com.au/about-diabetes/diabetes-in-australia/>

- Provide national and localised views of the potential budget for intervention, as well as evaluation of existing initiatives.
- *Models carry natural complexity limits* – It is easy to generate hundreds of potential outcomes of interest to build into a model, each with different drivers and interactions with other outcomes. This can quickly become too much for a model; for instance a model with 200 outcomes has 20,000 potential correlations between outcomes to consider. Health is particularly challenging, with hundreds of potential diagnoses and treatments. This means some wisdom is needed for the design of any supporting microsimulation. It may even be sensible to consider two models:
 - A cross-agency model that emphasises the high-value outcomes that can benefit from cross-agency thinking. This could include higher-level outcomes for employment, welfare, disability and NDIS, health (such as overall use and potentially preventable service use), aged care, child protection, justice, housing and education.
 - A more detailed health model that can properly recognise specific interventions (for example, interventions focusing on specific chronic diseases), and their future benefits in areas tightly related to the health sector.
- *Administrative datasets carry limitations* – Microsimulation models rely heavily on administrative data, often focusing on service use. These datasets do not always provide the answers we seek. For example, cessation of mental health services may be a positive outcome (if a person has improved their mental health) or poor (if their health has not improved, but they have stopped treatment for other reasons). Similarly, an exit from social housing may be positive (successful transition to the private market) or negative (a person has failed to hold their tenancy and has become homeless). Limitations need to be understood to avoid perverse incentives, such as interventions that reduce service usage for people who still need it.
- *Giving broad access to a model is helpful* – If individual departments can readily use model outputs, then a model can quickly become a shared resource valued by stakeholders. Departments are often best placed to design programs, and benefit from being able to see directly how interventions might generate benefits across sectors. The Victorian EIIIF is a good example of this approach.
- **Timely linked data remains a challenge** – Good cross-agency data work often relies on high quality linked data. Short turnarounds between data generation and linkage improves the ability to monitor and improve nimbly. There remain significant challenges to achieving this, particularly linking datasets across different tiers of government.

There are also large inefficiencies in current processes: linkages that are discarded rather than reused, lengthy approval processes for projects that are clearly in the public interest, and delays related to under-resourced linkage agencies. For example, the NSW Pathways to Homelessness project¹⁰ combined state and federal data for 600,000 people across 19 services to understand risks and outcomes related to homelessness. The project took four years, with the vast bulk of that time waiting for ethics, custodial approval, and linkage. The dataset, representative of the entire state, was then destroyed at the end of the project. While progress is being made, we think significant improvements in data linkage governance and implementation are still possible.

- **There are large opportunities for improved evaluation** – We regard good evaluation as core to the framework, since spending on prevention needs to be accountable.

¹⁰ <https://www.nsw.gov.au/sites/default/files/noindex/2025-01/pathways-to-homelessness-final-report-december-2021.pdf>

- *A microsimulation model can be the starting point for quantitative evaluation* – Such a model projects future outcomes under the status quo, so can form a counterfactual (which is often the hardest thing to estimate).
- *Many programs would benefit from longer-term evaluation* – Often funding cycles dictate the timing of evaluations, with a consequence that medium and longer-term outcomes, which may need a year or two to emerge, are never measured. Even if a program receives a short-term evaluation, we would support ongoing monitoring and evaluation. This can even include analysis of programs that are defunded – this can still be incredibly valuable evidence for future planning.
- *Standardisation of outcomes and economic value is useful* – Inconsistent approaches to economic evaluation hamper the ability to meaningfully compare the relative value of interventions. Guidance to improve consistency will be valuable. A good example of this is the Family and Community Services Insights, Analysis and Research (FACSIAR) unit, who have recently released their benefits catalogue, which will improve consistency across a fair range of outcomes.¹¹

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 strategies?

- **Improving prevention and Public Health funding transparency** – Consideration must be given to the transparency of funding flows for prevention activities, some of which are currently covered under Public Health funding. For example, activities such as cancer screening programs receive both Commonwealth and State and Territory funding – only some of which flows through the National Health Funding Pool. This makes it difficult to determine the current funding levels for each initiative,¹² as well as total level of prevention program funding. The funding options proposed by the Interim Report can be further supported by improving the use of existing processes for administering funds, such as facilitating greater inclusion, clarity and reporting of Public Health and prevention program payments through the National Health Funding Pool.

4 Final comments

We thank you for the opportunity to make a submission, and would be happy to discuss any of the issues raised further if needed.

Yours sincerely

Anna Cohen
Principal

Hugh Miller
Principal

¹¹ <https://dcj.nsw.gov.au/documents/about-us/facsiar/facsiar-publications-and-resources/dcj-benefits-database-standard-values-human-services-cost-benefit-analysis.pdf>

¹² Alan Shiell et al., How do we fund Public Health in Australia? How should we?, Australian and New Zealand Journal of Public Health, volume 48, Issue 5 (2024), <https://doi.org/10.1016/j.anzjph.2024.100187>.