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# St Lukes submission to the Productivity Commission Inquiry

Delivering quality care more efficiently

## Executive Summary

St Lukes is a leading Tasmanian not-for-profit health organisation, supporting over 90,000 individuals across the state. While we operate within the private health insurance sector, our role extends far beyond coverage—we are a committed community health partner driving long-term, place-based reform. Positioned at the intersection of public, private, and community health, we bring a unique, system-wide perspective and a strong mandate to lead.

In the past two years, we have invested more than $18 million in preventative health programs that promote nutrition, movement, social connection, and equitable access to care—demonstrating our commitment to improving population health outcomes at scale.

The Productivity Commission's interim report identifies three reform priorities that St Lukes strongly supports:

### 1. Reform of quality and safety regulation

Fragmented, duplicative regulatory requirements are one of the greatest drags on productivity in the care economy. For small states like Tasmania, these burdens are amplified, discouraging providers and overwhelming frontline workers. We support a nationally aligned framework, including a single worker registration and accreditation system, but emphasise that regulatory culture must shift from compliance-policing to support-first. Regulation should build workforce capability, reduce duplication, and maintain a clear focus on client wellbeing.

#### Principles for Support-First Regulation:

- Quality and safety remain paramount – client wellbeing and safe care as the primary outcomes.
- Enable, don't just enforce – regulators should act as partners, not just compliance enforcers.
- Reduce duplication and complexity – a single national registration, accreditation, and audit system.
- Respect workforce realities – migrant and lower-skilled workers thrive when supported.
- Drive continuous improvement – use data and outcomes to identify and scale best practice.

### 2. Embedding collaborative commissioning

Commissioning that genuinely brings together governments, providers, and communities, including private industry, has the potential to reduce fragmentation and ensure place-based responses to health needs. Yet rigid funding models and centralised governance risk undermining this reform. In Tasmania, a single Primary Health Network creates the risk of decision-making driven through a central, MM1 & MM2 lens, neglecting the nuances of regions like the North-West and East Coast. St Lukes large membership base, spanning all regions and demographics, provides us with unparalleled insight into community needs and makes us an essential partner in collaborative commissioning.

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### Principles for Collaborative Commissioning:

- Noses in, fingers out – governments set objectives, undertake oversight and review, providers deliver.
- Place-based representation – governance must reflect diverse regional voices.
- Partnership beyond government – PHIs, NGOs, and community providers as equal partners.
- Funding based on need, not just numbers – prioritise small but high-disadvantage communities.
- Flexibility and accountability in balance – allow local innovation within clear accountability.

## 3. A National Framework for Prevention Investment

Prevention is the single greatest opportunity to improve population health and reduce long-term system costs, yet it remains chronically underfunded and vulnerable to election cycles. Tasmania demonstrates the urgency: despite some of the worst health outcomes in the nation, only around 3% of the state's health budget is directed to prevention. A quarantined National Prevention Investment Future Fund, backed by bipartisan commitment and mandatory state/territory co-investment, would provide the long-term certainty needed to scale proven interventions. Tasmania is the logical pilot state for this framework, where St Lukes' has already been advocating for a similar model.

### Principles for Prevention Investment:

- Long-term commitment – funding horizons of at least twenty years with bipartisan support.
- Shared accountability – mandatory co-investment across all jurisdictions.
- Outcomes over activity – prioritise measurable results, not just service volumes.
- Noses in, fingers out – government oversight with delivery by capable private/community providers.
- Regional testbed approach – pilot in high-need, small-scale jurisdictions like Tasmania.

In our detailed submission, St Lukes urges the Commission to seize this once-in-a-generation opportunity. Tasmania's scale and challenging health profile make it representative of many MM2 – MM7 regions and the perfect test bed for national reform. With aligned regulation, collaborative commissioning, and sustained prevention investment, we can prove that it is possible to deliver quality care more efficiently — and in doing so, provide a blueprint for regional Australia.

## Recommendations

To support the Productivity Commission's vision for delivering quality care more efficiently, St Lukes has identified a set of practical, evidence-based recommendations to inform the Commission's next steps. These recommendations build on Tasmania's unique context as a small state with some of the nation's most challenging health outcomes, while also offering scalable solutions for national reform. Together, they provide a roadmap for aligning regulation, embedding collaboration, and investing in prevention in ways that will deliver measurable outcomes for communities and greater productivity for the care economy.

1. Establish a single national registration and accreditation system for care workers and providers, trialled in Tasmania.
2. Transform regulators into supportive, capability-building bodies.

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3. Embed standardised data reporting across all care sectors, linked to funding.
4. Ensure private health providers are included as equal partners in collaborative commissioning.
5. Create regional advisory boards in Tasmania to reflect distinct health regions.
6. Pilot the National Prevention Investment Framework in Tasmania.
7. Tie prevention funding to measurable outcomes, with mandatory co-investment from states and territories.
8. Apply a 'noses in, fingers out' principle across all reforms to separate governance from service delivery.

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## Introduction

At St Lukes, we believe Tasmania offers a unique regional lens that is vital to shaping national health reform. As a not-for-profit health organisation advocating, curating and providing across public, private, and community sectors, we bring a holistic understanding of the state's most pressing health challenges—and the innovative, practical solutions already making a difference on the ground.

We're not just a health insurer; we're a community health partner with a bold vision: to make Tasmania the healthiest island on the planet by 2050. With over 90,000 lives covered and $18 million invested in preventative health initiatives over the past two years, we're already delivering impact through programs focused on nutrition, movement, connection, and improved access to care.

Our submission to the Commission reflects both our responsibility and readiness to lead. We see Tasmania as the ideal testbed for a national prevention investment framework - an opportunity to prove the productivity and population benefits of long-term, place-based preventative care. This is a once-in-a-generation chance to shift the dial on life expectancy and chronic disease, not just for Tasmania, but for all regional Australia.

We are pleased the Productivity Commission's key interim recommendations reflect a similar course especially in the cost benefit effects of sustainable and planned preventative investment.

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## 1. Reform of Quality and Safety Regulation

The Commission is correct to highlight that fragmented regulation is one of the greatest drags on productivity in the care economy. Providers are required to navigate multiple systems of worker screening, accreditation, and audits that vary by sector and jurisdiction. For Tasmania, with thin markets and small provider scale, the costs of duplication are amplified. The ultimate cost is borne by the clients who must navigate the complex systems and compliance issues as opposed to seamless and timely access to care.

St Lukes strongly supports national alignment of quality and safety regulation, with an emphasis on the following:

1. The unified accreditation process should extend to a single national registration and screening system that applies across all care sectors. Such a system would provide every entity with a consolidated view of a care worker's credentials, compliance, and screening status, ensuring consistency and reducing duplication. For care workers, it would remove the burden of navigating multiple application processes, cutting down on time, cost, and confusion. Importantly, it would also strengthen public trust and regulatory oversight by creating a transparent, efficient, and portable framework for workforce management.

2. Regulators must shift culturally from compliance-policing bodies to support-first regulators. The current approach creates significant risks for providers, particularly smaller not-for-profits, where the cost and time involved in meeting multiple regulatory requirements often outweigh already limited resources. Many of these organisations are governed by voluntary boards that carry personal liability but lack the technical capacity to navigate complex systems, discouraging capable organisations from continuing to deliver care at a time when community-based providers are most needed.

3. At the frontline, the workforce feels the strain acutely. In aged care and the NDIS, many roles are filled by migrant workers or those with lower educational thresholds, who are easily overwhelmed by compliance-heavy requirements. This contributes to turnover and undermines confidence. By contrast, a supportive regulatory approach would focus on building capability and resilience, with regulation that is consistent, accessible, and paired with education and guidance. The Productivity Commission has noted that fragmented and duplicative auditing is costly and counterproductive. Moving to an enabling model would allow staff to focus on care while lifting standards through education and shared best practice. Importantly, this would not reduce the focus on client safety – safeguarding wellbeing must remain paramount – but would achieve it through supportive and educative mechanisms. Tasmania, with its smaller workforce and thin markets, offers an ideal test case to demonstrate how a supportive regulatory culture can reduce disincentives for providers, empower workers, and improve outcomes without unnecessary administrative burden.

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4. Data submission requirements should be embedded through a standardised suite of metrics linked directly to funding from all sectors. A nationally consistent framework would replace the current patchwork of siloed reporting, enabling meaningful comparison across aged care, disability, health, and other parts of the care economy. A minimum data set across aligned sectors would be the key enabler to achieve this. Linking funding to these metrics would incentivise providers to demonstrate outcomes rather than process compliance, while also allowing governments and regulators to identify innovation and excellence and scale best-practice models nationally. Standardisation would also significantly reduce duplication for providers, who currently prepare multiple versions of essentially the same data for different authorities. For Tasmania, where providers often span several care sectors within thin markets, this reform would be especially valuable, freeing up capacity for direct client care while ensuring rigour, accountability, and transparency.

5. Access to funding should be linked to mandatory alignment with the regulatory framework, ensuring consistency and quality. Currently, providers may operate under different standards depending on the program or sector through which they are funded, leading to variation in quality and consumer experience. Making alignment a condition of funding would establish a consistent baseline across the care economy, giving clients confidence that safeguards and expectations are uniform wherever care is delivered. It would also prevent cost-shifting or the delivery of services under less stringent frameworks. In smaller jurisdictions such as Tasmania, the risk is that providers "cherry pick" less-complex clients, leaving service gaps and long waits for those with greater needs. By tying funding to a unified framework, governments can drive cultural change towards continuous improvement, rather than fragmented compliance. For Tasmania's multi-sector providers, mandatory alignment would simplify expectations, improve transparency, and strengthen client outcomes without adding administrative burden.

Tasmania's small scale offers a testbed for a simplified, nationally aligned regulatory environment. By trialling unified accreditation, registration, and audit in Tasmania, the Commonwealth could model efficiencies that are then rolled out nationally.

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In summary, we support the following principles to underpin reform in this area:

## Principles for Support-First Regulation

1. **Quality and safety remain paramount**
   Client wellbeing and safe, high-quality care are the primary outcomes, with supportive regulation strengthening rather than weakening these standards.

2. **Enable, don't just enforce**
   Regulators act as partners in capability-building, providing education, guidance, and practical tools, rather than relying solely on compliance enforcement.

3. **Reduce duplication and complexity**
   A single national registration, accreditation, and audit system removes unnecessary burden, freeing providers to focus resources on client care.

4. **Respect workforce realities**
   Many care roles are filled by migrant and lower-skilled workers who thrive when supported. A supportive regulator culture increases workforce confidence, reduces turnover, and enhances quality outcomes.

5. **Drive continuous improvement**
   Regulation should identify and share best practice, using data and outcome measures to scale what works across the care economy.

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## 2. Embedding Collaborative Commissioning

Collaborative commissioning – where organisations plan, procure, and evaluate services together, is critical to reducing fragmentation and better meeting local needs. It enables governments, providers, and communities to co-design services that are more responsive to population health challenges, rather than relying on centrally prescribed programs that may not reflect local realities.

The Productivity Commission's interim report highlights this ambition, but it also makes clear that the design of governance and funding models will determine success or failure. If collaborative commissioning is overlaid with rigid rules, short-term contracts, or centralised decision-making, it risks becoming a symbolic reform rather than a practical one.

In Tasmania, where there are only a single Primary Health Network and a history of planning, a risk of a centralised lens of MM1 & MM2 perspectives is particularly acute, without flexibility, the state's regional needs (such as those of the North-West or East Coast for example) may continue to be overlooked. For collaborative commissioning to succeed, governance must be inclusive and funding mechanisms must allow place-based decisions that reflect and are informed by the diversity of communities across Modified Monash regions.

St Lukes agrees with the intent but emphasises the following areas.

1. The private health sector must be considered as a key partner, alongside PHNs, LHNs, and ACCHOs, in any collaborative commissioning model. In regions classified as MM2–MM7, the number of service providers and funders is limited, and private health organisations are often among the few entities with the scale, infrastructure, and community trust to deliver meaningful solutions. Ultimately, PHI's are a part of the health system and must be included in the collaborative commissioning process.

2. St Lukes, as Tasmania's largest private funder of sick care and investor in prevention, with more than 90,000 members, has unparalleled insight into the health needs and challenges of Tasmanians. Our membership base reflects every demographic and region of the state, from urban centres to small rural communities, giving us a uniquely comprehensive picture of demand pressures, service gaps, and consumer expectations. This makes us particularly well placed to partner with government in shaping services that are both equitable and efficient. By excluding private health industry from the commissioning process, governments risk losing access to this rich source of lived community insight and the opportunity to co-invest with organisations that already have strong connections across the care system. As not-for-profit providers already working within the care system, it also risks contributing to further fragmentation and potential gaps and/or duplication of services.

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3. Governance must reflect true place-based representation if collaborative commissioning is to succeed. As noted above, in Tasmania, the presence of only a single Primary Health Network creates a significant risk of overcentralisation, with decisions dominated by centralised, MM1 & MM2 based perspectives and insufficient attention paid to the distinct needs of regions such as the North-West Coast, the Southern Midlands, or the East Coast. These areas face very different health profiles, service access challenges, and demographic pressures compared to metropolitan centres, and yet under a single governance lens their priorities are often overlooked. Additional regional representation, based on, for example, three regions, our five electoral boundaries or similar, would contribute to ensuring commissioning decisions are informed by the realities of diverse communities. This kind of structure would also align with the Productivity Commission's own recognition that regional contexts matter, particularly in states with small populations and thin service markets. For Tasmania, embedding genuine regional knowledge, experience and voices in governance arrangements would build trust, improve the targeting of funding, and make commissioning responsive to the Modified Monash classifications and social determinants of health that define the challenges of smaller and more remote communities.

4. Funding should be allocated not only on the scale of a population but also on the intensity of population need. Current funding formulas too often rely on headcounts, which disadvantages smaller regional or rural communities that face disproportionately high levels of chronic disease, lower life expectancy, and barriers to accessing care. In Tasmania, this issue is stark: communities such as Bridgewater or the West Coast are relatively small in population terms, but their health outcomes are among the worst in the nation, with life expectancy gaps of nearly 20 years compared to more affluent suburbs. This is exacerbated across the social determinants of health to become a "wicked problem" for policy makers and funders. If funding is distributed solely on a per-capita basis, these high-need communities' risk being perpetually underfunded despite their greater burden of illness and social disadvantage. Prioritising need alongside population scale would allow commissioning to focus resources where they can make the most difference — reducing preventable hospitalisations, improving equity, and addressing the drivers of long-term system costs. This approach is consistent with the Productivity Commission's emphasis on outcomes-focused care and would ensure that scarce health dollars are invested where they will deliver the greatest impact.

5. Governments should adopt a "noses in, fingers out" approach, where their role is centred on governance, compliance oversight, and outcomes measurement, while the actual delivery of services is left to capable providers.

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6. This ensures that governments retain a clear line of sight over public accountability and performance, without displacing or duplicating the expertise that already exists within the health and community sector. Too often, government agencies drift into direct service provision or micro-management of program delivery, which can create inefficiencies, blur accountability, and stifle innovation. By contrast, empowering providers — who are closer to communities and better placed to design flexible, responsive services — results in higher quality care and greater trust from those receiving it. For Tasmania, where service markets are thin and every provider resource is precious, government stepping back from delivery and focusing instead on enabling, monitoring, and evaluating outcomes would ensure that commissioning dollars flow to front-line impact rather than bureaucratic process both building capability and resilience.

In summary, the principles we recommend for collaborative commissioning are:

## Principles for Collaborative Commissioning

1. **Noses in, fingers out**
   Governments focus on governance, compliance, and outcomes measurement, while empowering providers to design and deliver services.

2. **Place-based representation**
   Commissioning structures must reflect regional voices, not just centralised decision-making, to ensure diverse community needs are recognised.

3. **Partnership beyond government**
   Private health insurers, NGOs, and community providers must be equal partners alongside PHNs, LHNs, and ACCHOs.

4. **Funding based on need, not just numbers**
   Allocation must account for the intensity of population health needs, ensuring smaller but high-disadvantage communities are prioritised.

5. **Flexibility and accountability in balance**
   Governance should provide accountability and oversight while allowing local innovation and adaptability in program design.

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## 3. A National Framework for Prevention Investment

The Commission's proposal for a National Prevention Investment Framework is essential to achieve long-term productivity and health outcomes. Unlike short-term interventions, prevention requires consistent investment across decades, yet it is too often sidelined by electoral cycles that favour immediate results over generational change. St Lukes has been advocating for a dedicated prevention fund at both State and Federal levels precisely because prevention is chronically underfunded despite being the most effective way to reduce health system demand.

Tasmania illustrates this need clearly: despite having some of the nation's worst rates of preventable illness and chronic disease, only approximately 3% of the state's health budget is directly allocated to prevention. Without structural reform to embed long-term, quarantined funding, Tasmanians will continue to experience avoidable hospitalisations and shortened life expectancy, continuing the cycle of system inefficiency.

A national framework, underpinned by bipartisan agreement and mandatory co-investment by states and territories, offers the structural certainty required to shift the dial and deliver meaningful change.

Our position is outlined here:

1. A dedicated National Prevention Investment Future Fund must be established, with bipartisan commitment to funding over a minimum twenty horizon to reflect the return on investment. Prevention initiatives rarely yield results within a single budget cycle; they require sustained effort over years to influence behaviours, reduce chronic disease prevalence, and demonstrate measurable reductions in hospitalisations. Short-term or ad hoc funding undermines confidence for providers, discourages innovation, and limits the ability to properly evaluate outcomes. A quarantined, long-horizon fund would provide certainty for governments, providers, and communities, ensuring that effective programs have the time and scale needed to deliver impact. Bipartisan agreement is critical, removing the risk that election cycles interrupt or reverse progress. This kind of long-term funding mechanism would allow governments to shift from reactive spending on acute care to proactive investment in prevention — an approach that is more productive, more cost-effective, and better aligned with community expectations. For Tasmania, where preventable chronic illness is a leading cause of hospital demand, such a fund would enable initiatives to be scaled and evaluated as a national blueprint for prevention.

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2. Co-investment from states and territories should be mandatory, removing the option for jurisdictions to opt in or out based on political cycles. Allowing participation to be discretionary risks creating a patchwork of investment where some communities or jurisdictions benefit from prevention initiatives while others are left behind. This approach entrenches inequity rather than addressing it. A nationally consistent co-investment requirement would ensure that all Australians, regardless of where they live, have access to the same level of preventative health funding and programs. It would also signal shared accountability, with both levels of government committing resources and responsibility for improving population health outcomes. For smaller states such as Tasmania, mandatory co-investment provides an assurance that local needs will be recognised and resourced within the national framework, rather than being sidelined by larger states with greater bargaining power. This consistency is critical to building trust in the system and to achieving the long-term productivity benefits that the Productivity Commission has identified as essential to health reform.

3. Funding mechanisms should be tied to outcomes. Programs that demonstrate reductions in preventable hospitalisations, improved life expectancy, and measurable community wellbeing should be prioritised for continued funding. At present, too much investment in health is tied to inputs or activity levels — how many services are delivered or how many people attend a program — rather than whether the intervention leads to tangible improvements in health. This creates a system where providers may meet contractual obligations without necessarily improving outcomes for clients. By linking funding directly to outcomes, governments can create powerful incentives for innovation and continuous improvement, rewarding providers who deliver measurable value. This approach would also enable the scaling of programs that are proven to work, building an evidence base of best practice across different regions and populations. In Tasmania, where hospitalisation rates for chronic conditions are among the highest in the nation, shifting the focus from effort to impact would ensure that limited funding delivers maximum benefit to communities. It would also build accountability and transparency, showing taxpayers that prevention investments deliver real, measurable returns. More effective reporting on cost returns requires the longest investment cycle, given the time needed for change to take effect.

4. As with collaborative commissioning, a “noses in, fingers out” principle should apply. Governments should oversee effectiveness and return on investment (ROI), but service delivery should remain with the private and community sectors best placed to innovate and respond. This separation of roles ensures clarity of accountability and prevents governments from becoming both funder and provider, which can create conflicts of interest and inefficiencies. By focusing on oversight and evaluation, governments can ensure that prevention funds are used effectively and that

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outcomes are transparently measured against agreed metrics. At the same time, empowering providers allows the expertise, flexibility, and community knowledge of private and not-for-profit organisations to drive program design and delivery. This is particularly important in Tasmania, where small-scale providers are deeply embedded in their communities and can adapt services to meet local needs more quickly than a central bureaucracy. International experience shows that when governments retain strategic oversight but enable non-government partners to innovate, prevention initiatives achieve better uptake and more sustainable results. Applying this approach will ensure that a National Prevention Investment Framework remains both accountable and responsive, delivering maximum value for communities and taxpayers alike.

5. Tasmania is the logical pilot for this framework. With some of the worst preventable health outcomes in the nation, high chronic disease rates, and predominantly MM3–MM7 classifications, Tasmania offers the opportunity to demonstrate the effectiveness of prevention investment in a regional setting.

In summary, St Lukes recommends the following principles for a National Framework for Prevention investment.

## Principles for Prevention Investment

1. **Long-term commitment**
   Prevention requires sustained investment over years, not short funding cycles. A minimum twenty-year horizon with bipartisan support is essential to deliver meaningful returns.

2. **Shared accountability**
   Co-investment from both Commonwealth and state/territory governments must be mandatory, ensuring consistency across the federation and equity for all Australians.

3. **Outcomes over activity**
   Funding should be tied to measurable results such as reduced preventable hospitalisations, increased life expectancy, and improved community wellbeing, rather than just service volumes.

4. **Noses in, fingers out**
   Governments oversee effectiveness, governance, and ROI, while delivery is led by private and community sectors best placed to innovate and respond to local needs.

5. **Regional testbed approach**
   Pilot programs in high-need, small-scale jurisdictions like Tasmania can demonstrate impact, build evidence, and provide a blueprint for wider national rollout.

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## Conclusion

Australia's care economy must become more productive, but productivity in care cannot be measured simply as 'more output per worker.' True efficiency lies in delivering better outcomes: fewer hospitalisations, improved quality of life, and longer healthy lifespans.

St Lukes offers government a trusted, innovative partner with deep commitment and experience in community health. We are ready to help implement the Productivity Commission's vision by:

- Supporting the piloting regulatory alignment, collaborative commissioning, and prevention frameworks in Tasmania.
- Bringing the private sector's perspective into reform processes.
- Providing support in testing "what works" for scaling of successful models nationally to benefit all Australians.

With the right frameworks, we can together shift the dial from a singular focus on acute and band-aid care to long-term health investment – ensuring that Tasmania, and Australia, becomes healthier, more resilient, and more productive.