AUSTRALIAN INSTITUTE OF HEALTH INNOVATION
Faculty of Medicine, Health and Human Sciences

MACQUARIE University
SYDNEY·AUSTRALIA

Professor Jeffrey Braithwaite
Founding Director
Immediate Past President, the International Society for Quality in Health Care (ISQua)

15 September 2025

Productivity Commission
Delivering Quality Care More Efficiently

Dear Sir / Madam,

RE: 'DELIVERING QUALITY CARE MORE EFFICIENTLY' INTERIM REPORT

Thank you for providing an opportunity to comment on the interim report titled 'Delivering quality care more efficiently'. This letter provides the collective views of the Macquarie University's Australian Institute of Health Innovation (AIHI) on recommendations made by the Productivity Commission, and offers additional evidence-based research insights for the Government to consider on how to improve care market productivity.

About AIHI

AIHI is Australia's first and largest fully integrated health sciences research institute, engaged with 152 countries, nurturing over 200 relationships with partners and stakeholders, and managing 160 research projects valued at $60 million. AIHI consists of four University research centres including:

- Centre for Healthcare Resilience and Implementation Science (CHRIS)
- Centre for Health Systems and Safety Research (CHSSR)
- Centre for Health Informatics (CHI)
- Macquarie University Centre for the Health Economy (MUCHE)

AIHI takes a systems and social perspective to addressing challenges in the care economy. More information can be found on our website.

Reform of quality and safety regulation

We agree with the Productivity Commission that aligning safety and quality regulation in the care economy could reduce administration costs and increase productivity. However, aligning

Macquarie University
NSW 2109 Australia
T: +61 (2) 9850 2401
M: +61 414 812 579
F: +61 (2) 8088 6234
E: jeffrey.braithwaite@mq.edu.au
aihi.mq.edu.au

regulation across aged care and disability care sectors will be challenging and may come with significant cost to government and providers, particularly given these sectors are already undergoing significant change. This cost may divert resources away from delivering care unless the cost of change is compensated by the Government. We therefore recommend further research be undertaken to estimate the net economic benefit of alignment before being accepted by Government.

The Government may also want to consider other avenues to improve safety and quality in care markets. Ideas based on our research are presented below.

- Our research on harmonising workplace health and safety legislation in Australia suggests reduced adverse workplace events is associated with stronger enforcement activity and increased managerial focus on safety, rather than harmonisation alone (1). Safety and quality benefits are therefore likely within aged care and disability care if Government invests more in developing stronger quality metrics that reflect value, along with monitoring outcomes and enforcement of current regulation.
- Better understanding of what constitutes value and aligning quality metrics in the care economy would help providers understand their performance relative to their peers, potentially reducing the significant gap in evidence based care found in care markets (2-4). Coupled with useful public information on quality, it could help consumers choose services they value most. The evidence for this is mixed however (5-7).
- Improved safety and quality could come from incentivising care providers to work across organisations to use benchmarking data to address recognised quality of care issues, and develop and implement interventions to support best practice. Models such as our National Health and Medical Research Council funded National Aged Care Medication Roundtable bring together multiple aged care providers to share their data, learn from each other and trial and test interventions to improve medication outcomes (the most frequent source of error and complaint in the sector). A common informatics and analytics infrastructure could reduce unnecessary duplication of quality efforts, leverage national indicator data assets and produce better outcomes for staff and residents (8).

Macquarie University
NSW 2109 Australia
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M: +61 414 812 579
F: +61 (2) 8088 6234
E: jeffrey.braithwaite@mq.edu.au
aihi.mq.edu.au

- An alternative to aligning safety and quality regulation is to further refine and align market regulation given care sector settings are not optimally set up to encourage provider investment in quality. This should include further research on how best to incentivise and allow providers to produce care quality above a minimum threshold by increasing the sensitivity of demand to quality, increasing the regulated price for care, decreasing the marginal cost of quality, and increasing competition (9).

Any significant change to regulation that impacts safety and quality should involve substantial consumer consultation, particularly for culturally and linguistically diverse groups who can be at higher risk of safety events due to language and cultural barriers (10).

Embed collaborative commissioning

We agree with the Productivity Commission that care economy funding reform is essential for improving productivity.

However, we caution the Government on moving towards collaborative commissioning without undertaking substantial additional research. We need further evidence on the best way to structure commissioning groups (contractually and geographically), and how to identify appropriate governance arrangements and allocate responsibility and accountability. It is not clear whether commissioning groups would have access to requisite skills and experience to commission services and monitor outcomes, and to develop funding models that can support value based care. Any transition should be undertaken by first trialling alternative commissioning arrangements that are accompanied by comprehensive evaluations taking a systems approach.

Our concerns are primarily derived from the English National Health Service's (NHS's) experience in commissioning, where there is scant evidence that clinical commissioning groups have integrated care at scale, or delivered improved health outcomes (11). Recent reforms towards Integrated Care Systems in England, a shift away from clinical commissioning to greater partnerships with a broader range of health and social care stakeholders, suggests that English commissioning groups have faced significant challenges to their effectiveness (12).

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The Government may want to consider other funding reform options to increase care market productivity. Aligning with the Australian Government's intent to shift funding towards paying for value (13), our research has developed a roadmap for introducing scalable value based payments in Australian healthcare. It provides four recommendations, presented below (14).

- Develop a cohesive vision and ambitious national 10-year plan for value-based payment integration into the healthcare system.
- Create an independent national payment authority to implement the national plan through strong relationships with relevant federal government agencies and with state and territory governments.
- Improve cost and outcome data collection, analysis and access among government and providers, aiming for seamless, low cost collection and effective flow of information.
- Support provider education and innovation by investing in information technology infrastructure, identifying and promoting best practice care, developing provider tools, and promoting peer-to peer learning.

Any large-scale healthcare system funding reform in Australia will be complex, having to upend firmly entrenched care processes, business models and siloed knowledge. Our research suggests that large scale healthcare system transformation be accompanied by four system enablers, including (i) an authorising environment (ii) relevant, authentic, timely, and meaningful data (iii) distributed leadership and decision making (iv) support for the emergence of a learning culture, to establish positive feedback loops to direct ongoing and beneficial systems change (15).

A national prevention investment framework

We agree with the Productivity Commission that further investment in prevention by government is needed, and we agree that a National Prevention Investment Framework is worthwhile. However, we recognise that developing a national framework across our federated system comes with process, coordination and political challenges. While some prevention programs will deliver immediate benefits, such as vaccination programs, others may take 5-10 years or much longer. This is particularly the case for prevention activities that target early

Macquarie University
NSW 2109 Australia
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F: +61 (2) 8088 6234
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aihi.mq.edu.au

childhood and young people, where benefits sometimes only materialise much later in life - over decades.

The Government may want to consider other national investment frameworks in healthcare that could have a more proximal impact on productivity, such as improving mental health. Our research funded by a National Mental Health Authority grant undertook a national consultation of state, territory and federal government departments and agencies, along with 70 stakeholders to develop a national framework for a more coordinated approach to investment in mental healthcare (16, 17).

Our proposed national mental healthcare investment framework was based on investment processes already used by state, territory and federal governments, but adjusted to accommodate the unique investment characteristics of mental healthcare, such as considerable uncertainty regarding outcomes, incorporating benefits that extend beyond health outcomes (e.g., productivity) and active engagement of lived experience persons in the investment decision.

Our investment framework aims to address problems that are common to current investment in prevention. Valuable investment in mental healthcare models has often been made without supporting evidence in Australia (18). Limited ongoing evaluation of services means there is some uncertainty about whether previous investments in mental health and wellbeing have improved mental health outcomes (18-20). **We believe that introducing a national mental health investment framework could have an immediate impact on productivity** by helping government invest in mental healthcare programs that produce the best outcomes, and helping government disinvest in programs delivering low value care.

Conclusion

We have presented several alternative ideas the Government could consider to increase productivity in the care sector. This is not an exhaustive list. AIHI produces over 500 peer reviewed journal articles, books and chapters each year, on how to better organise and pay for care, ways to manage care delivery systems and optimise care quality and safety, and on how to embed new digital technology safely into clinical practice and the care economy. We welcome further discussions with the Productivity Commission.

Macquarie University
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T: +61 (2) 9850 2401
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E: jeffrey.braithwaite@mq.edu.au
aihi.mq.edu.au

Yours sincerely,




Professor Jeffrey Braithwaite
BA, DipLR and Law, MIR (Hons), MBA, PhD, FIML, FCHSM, FFPHRCP, FAcSS, Hon FRACMA, FAHMS
Professor and Director, Centre for Healthcare Resilience and Implementation Science
Founding Director, Australian Institute of Health Innovation

Professor Johanna Westbrook
BAppSc, GradDipAppEpid, MHA, PhD, FTSE, FAIDH, FACMI, FIAHSI
Director, Centre for Health Systems and Safety Research

Professor Enrico Coiera
MBBS, PhD, FAAHMS
Director, Centre for Health Informatics

Professor Henry Cutler
B.Bus, M.Ec (Hons) PhD, GAIDC
Director, Macquarie University Centre for the Health Economy
Research Associate, Health Economics Research Centre, University of Oxford

Australian Institute of Health Innovation, Macquarie University
Level 6, 75 Talavera Road, Macquarie University NSW 2109 Australia
jeffrey.braithwaite@mq.edu.au

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Macquarie University
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M: +61 414 812 579

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E: jeffrey.braithwaite@mq.edu.au
aihi.mq.edu.au

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