

Submission to the Productivity Commission:
in response to the 2025 interim report on
Delivering quality care more efficiently.

Susan J. Méndez
Jongsay Yong
Yuting Zhang

September 2025





MELBOURNE INSTITUTE OF
APPLIED ECONOMIC AND
SOCIAL RESEARCH

111 Barry Street
The University of Melbourne
VIC 3010, Australia

Corresponding:
Dr. Susan J. Méndez
Senior Research Fellow

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by

Dr Susan J. Méndez

Associate Professor Jongsay Yong

Professor Yuting Zhang

15 September 2025

Introduction

This submission is in response to the information requests in the interim report *Delivering quality care more efficiently* regarding the proposed **National Framework to support government investment in prevention**.

We highlight that the current fragmented, fee-for-service model provides no incentive for care coordination, leading to a high prevalence of chronic conditions, particularly among socioeconomically disadvantaged populations. The fragmentation of the system is also reflected in the collection and administration of data necessary for quality and safety reporting, and evidence-based evaluation and prioritisation.

We recommend that the Productivity Commission place greater emphasis on reforming the payment system and its impact on incentives, on developing program design and evaluation capacity, and on enhancing data infrastructure and linkage capabilities. Our core recommendations are as follows.

1. Reforming the payment and incentive system: We advocate for a shift from fragmented payments to integrated, outcome-based funding models. This approach would incentivise collaboration among providers in different settings, including nurses, allied health staff, GPs, non-GP specialists, and hospitals, to improve a patient’s overall health journey. This can be done at the system level; a natural starting point is primary care. Alternatively, it could be piloted for a specific cohort but this may be costly because the pool of beneficiaries may be too small. A specific high-priority group for this reform is older patients in residential aged care, who currently receive poor quality and costly care due to systemic fragmentation. We suggest piloting a bundled payment system with a single budget holder, modelled after the Department of Veterans’ Affairs (DVA) system, for this group.

2. Building program design and evaluation capacity by collaborating with researchers: We stress the need for a stronger evidence base to measure, monitor, and

assess the effectiveness of prevention programs. We recommend moving beyond correlational studies to embrace quasi-experimental methods and data science. The governments should facilitate and fund collaborations between practice and academics to build a credible knowledge base for health and social care programs across Australia.

3. Improving data and digital data infrastructure: A key limitation is the siloing of administrative data across different providers, which obscures insights into a patient’s full care journey. We recommend increased national efforts in data linkage and adoption of digital health technologies, such as electronic health records, to enable real-time information sharing. This would not only support more robust program evaluation but also facilitate care and practice leading to safer, more efficient, and patient-centred care.

A successful National Prevention Investment Framework must prioritise payment reforms, strengthen evaluation capabilities, and address data fragmentation to create a more integrated and effective healthcare system.

Prioritising and Assessing Prevention Programs (Information Request 3.1)

More than 60% of Australians live with at least one long-term health condition (AIHW, 2024). Individual behaviours, such as a poor diet, low physical activity, and non-adherence to medication or therapy, are associated with some of these conditions. However, health is determined by multiple factors that go beyond individual actions. Factors like limited access to healthcare services due to affordability or geographic barriers; financial stress and insecure employment; environmental conditions like inadequate housing, exposure to violence and food insecurity; and disparities in education and health literacy hindering an individual’s understanding of health risks and preventive measures, are highly relevant and can contribute to a high prevalence of chronic conditions in areas of high socioeconomic disadvantage. As a result, people in the most disadvantaged areas experienced a significantly higher burden of disease and premature death compared to those in the least

disadvantaged areas. For example, in 2018, the disability-adjusted life years (DALY) rate (a measure used in public health to quantify the overall burden of disease) in the lowest socioeconomic group was 1.6 times as high as in the highest group (AIHW, 2021).

When prioritising prevention proposals, the framework should heavily weight programs that drive integration and produce measurable improvements in patient outcomes and cost savings. The framework should prioritise the development of integrated care through **outcome-based funding models**. Instead of focusing on siloed services or tying payments to specific locations, incentives should be directed at a group of providers (e.g., community health services providers, GPs, non-GP specialists, hospitals) who are collectively accountable for a patient's overall health journey and outcomes.

By tying funding to shared outcomes, primary care networks and hospitals are incentivised to collaborate on community-based initiatives that manage chronic conditions and prevent acute episodes. The framework should aim to create financial incentives that align different organisations toward the shared goal of keeping patients healthy.

Programs and proposals should be assessed on their ability to generate cost savings through genuine collaboration, with key metrics being:

- Growth in use of community-based services and primary care, shifting the site of care out of hospitals.
- Reduction of unnecessary escalation in non-GP specialist visits per patient with chronic conditions, adjusted for complexity.
- Reduction of preventable hospital admissions.
- Timely follow-up after hospital discharge.

Implementing the National Prevention Investment Framework (Information Request 3.2)

For the practical implementation of the framework, payment reforms should be favoured as a key instrument to incentivise governments and providers to invest in prevention. Australia’s single-payer Medicare system offers a unique advantage for implementing innovative provider-based payment models that are more difficult in multi-payer systems.

Incentivising governments and providers: The most effective way to incentivise investment is through outcome-based joint funding. For example, Local Hospital Networks (LHNs) and Primary Health Networks (PHNs) could be jointly funded and paid only when they achieve shared outcomes, like reduced preventable hospital admissions. This structure avoids the “wrong pocket problem,” where the entity that funds a prevention initiative does not reap the financial benefits of its success.

Governance and budget rules: Implementation requires establishing clear, nationally consistent governance frameworks that mandate coordination, joint planning, and data sharing between organisations like LHNs and PHNs. To support this, existing budget operational rules may need to be adjusted to formally consider the “second-round” fiscal effects of prevention programs—that is, the long-term savings that accrue across different government portfolios.

Program evaluation and data infrastructure: Current evidence on the effectiveness of early-intervention, prevention, and multidisciplinary programs often relies on correlational studies limited to specific jurisdictions or small-scale initiatives of uncertain scalability.

Effective evaluation of prevention and integrated care programs requires more than documenting activities—it demands credible evidence that identifies which approaches deliver maximum benefits at minimum cost. While randomised controlled trials remain the gold standard for establishing causality, they are often prohibitively expensive and ethically problematic when withholding care could harm patients. Governments and providers,

therefore, need capacity to assess program success using alternative, state-of-the-art, evaluation designs and methodologies. Recent advances in **quasi-experimental methods and data science** should be leveraged for building a strong knowledge base.

This requires training and equipping evaluators with practical tools to build evidence and interpret findings appropriately. Similarly, government and provider organisations must learn to collect relevant data from program inception, ensuring that meaningful outcome evaluation can be made at appropriate stages of the program. Observational data from administrative records presents valuable alternative opportunities that can be used to supplement primary data collection in this regard.

At the moment, a key limitation of relying on administrative data for program evaluation is that **records are typically siloed across providers and custodians**, making it difficult to capture the full patient journey through the health system. This fragmentation obscures important insights into how patients use services from community health, general practice, hospitals, specialists, and allied health, and presents key obstacles to proper evaluation of the true impact of collaborative care initiatives.

Increased adoption of digital health technologies, such as electronic health records, has the potential to overcome these barriers by enabling real-time information sharing across settings. When patient records can follow individuals across providers, evaluators gain a more comprehensive picture of care pathways, outcomes, and costs, while clinicians benefit from better coordination, reduced duplication of tests, and earlier interventions. In this way, digital integration not only strengthens the evidence base for program evaluation but also directly supports the delivery of safer, more efficient, and more patient-centred care.

To strengthen the evidence base, we recommend that the government facilitates and funds collaborations across provider organisations, practitioners, and researchers to **build capacity in program design and evaluation**, with a view to advancing program evaluation methodologies and building a comprehensive and credible knowledge base for all health and social care programs in Australia.

Focus on Aged Care Patients

Older Australians, particularly those living in residential aged care, are a key group that tends to be heavy users of the healthcare system, and would benefit the most from improved, integrated prevention and care models.

Quality and efficiency gaps in aged care: While Australia’s healthcare system generally provides good quality and efficient care for older patients, there is a significant exception for those living in residential aged care homes. Our analysis of Victorian hospital data found that, after adjusting for risk factors, older patients in residential aged care received **lower quality of care**, with worse outcomes for mortality, unplanned readmissions, and hospital-acquired complications compared to older people living in the community (Yong and Yang, 2024). They also experienced **longer stays in hospitals**, indicating lower efficiency and higher costs for their care.

This demonstrates a failure of the current system, where this specific group of patients receives worse care that also costs more. The fragmented nature of funding and service provision—with different agencies managing hospital care, primary care, and aged care—makes care coordination difficult and is a major barrier to better outcomes (Uittenbroek et al., 2017; Stoop et al., 2020; Kim et al., 2021).

An integrated, prevention-focused solution: To address these systemic failings, we propose **an integrated, team-based care** approach centred on payment reform for older people in residential aged care. This approach would bring together professionals from primary care, hospital care, and aged care to focus on the person rather than a specific disease. Evidence suggests this model improves the quality of care as perceived by both patients and health professionals.

Bundled payments and a single budget holder: The current system provides no financial incentive for providers across different sectors to plan and coordinate care. We recommend a system of **bundled payments with a single budget holder** modelled

after the Department of Veterans' Affairs (DVA) system, as a policy innovation to drive integrated care for this specific, well-identified group of patients. The aim is to overcome the barriers created by funding streams coming from diverse sources with numerous spending restrictions that create incompatible incentives across providers and organisations.

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