

Submission to the Senate Select Committee on Productivity in Australia

Prof. Anthony Scott, Director, Centre for Health Economics, Monash University

Prof. Henry Cutler, Director, Macquarie Centre for the Health Economy, Macquarie University

Adjunct Professor (Practice) Bronwyn Croxson, Centre for Health Economics, Monash University

Prof. Kim Dalziel, Head, Melbourne Health Economics, University of Melbourne

Prof. Kees van Gool, Leeder Centre for Health Policy, Economics and Data, University of Sydney

Prof. Jane Hall, Centre for Health Economics Research and Evaluation, University Technology of Sydney

Prof. Julie Ratcliffe, College of Nursing and Health Sciences, Flinders University

Prof. Rosalie Viney, Director, Centre for Health Economics Research and Evaluation, University Technology of Sydney

Prof. Yuting Zhang, Melbourne Institute of Applied Economics and Social Research, The University of Melbourne

Correspondence to:

Prof. Anthony Scott, Director, Centre for Health Economics, Monash University
Anthony.scott@monash.edu

Summary

The focus of this submission is on productivity in the health care, aged care and disability care sectors (defined here as the ‘care economy’). The care economy is the largest employer in Australia, with the industry classification ‘Health Care and Social Assistance’¹ employing 2.4 million people (16.2 per cent of the workforce)². The productivity of this sector is key to Australia’s GDP growth, employment and the wellbeing of Australians.

Internationally, there is a focus on productivity in the care economy. Empirically and in most countries, productivity fell during the COVID-19 pandemic and has not yet recovered to pre-pandemic levels.³ At the same time, the care economy (and other sectors of the economy) faces rising input costs as cost of living pressures drive increased wage expectations and the unstable geopolitical context increases the price of imports, as well as rapid changes in technology with uncertain costs and effects.

The demand for care economy services is also growing rapidly from population ageing and increased longevity, rising expectations, widening diagnostic definitions, and increasing numbers of people with complex chronic conditions. The 2023 Intergenerational Report noted three of the five main budget spending pressures are related to the care economy, including health, aged care and the National Disability Insurance Scheme.⁴ This has not changed. In this context, getting the most value from scarce resources devoted to the care economy matters.

It is challenging to measure and improve productivity within the care economy⁵. The “production process” is complex and labour-intensive with little scope for capital deepening, and there are multiple outputs and outcomes with complex drivers.

It is also challenging to discuss productivity within the care sector since it is often misconceived as implying that the workforce is not working hard enough, or as a simple cost-cutting exercise. From an economics perspective, this is about the achieving a better (more efficient) allocation of resources. In a recent review of UK National Health Service, Lord Darzi addressed this head-on and defined productivity in terms of value. *“Regrettably, productivity in the NHS has all-too-often become associated with simply spending less or working harder. Neither is correct. Narrowly, productivity is the output, in terms of quantity and quality, produced relative to input. What it is really about is how much healthcare value can be created with the resources available”*.⁶

Getting the best value from scarce care economy resources requires the government to make tough spending choices given there is always a trade-off: each choice has an opportunity cost. These choices can be made only with robust decision-making processes, carefully designed decision rights and institutional arrangements (e.g. devolved decision making), and robust, trusted data on costs, outputs and outcomes.

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¹ This also includes childcare and community services, but we do not address these in this submission

² <https://www.jobsandskills.gov.au/data/occupation-and-industry-profiles/industries>

³ <https://www.sciencedirect.com/science/article/pii/S294985622300003X>, 11726G.

⁴ <https://treasury.gov.au/sites/default/files/2023-08/p2023-435150.pdf>

⁵ <https://www.abs.gov.au/articles/primer-labour-productivity>

⁶ <https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england>, page 71, emphasis added.

Health economists have a unique toolbox for applying robust methods to measure care economy productivity, especially output, health outcomes and wellbeing. They also have a unique understanding of the nature of market failures in the care economy and so how such measures should be applied and the nature of regulation. In addition, the design and evaluation of policies to determine the most effective drivers of productivity growth can provide evidence supporting governments to design and implement the best feasible institutional arrangements, and evidence to government to support tough spending choices. Australia was the first in the world to mandate the use of economic evaluation to evaluate new medicines. Australian health economists are now world leaders in health technology assessment and health outcome measurement.

We recognise that there are different uses for measures of productivity and health outcome measures, from incorporation in the national accounts down to their granular use by health and care professionals to improve the quality of care, and the use by governments to monitor and fund high value care. Measurement for these different purposes should be co-ordinated such that routine on-the ground measurement can be aggregated to national measures to be used in the national accounts. This requires the routine use of generic preference-based quality of life (e.g. EQ-5D) and wellbeing measures before, during and after receipt of services, or the mapping of different measures into a single index.

However, Australia lags far behind other countries in integrating these measures into national accounts. For example, the UK Office for National Statistics published the first NHS productivity estimates in 2005⁷. The ABS⁸ and the Productivity Commission⁹ are developing measures of healthcare productivity: to date their methods capture only part of the healthcare system and do not capture other parts of the care economy. No agreed methodology exists in Australia that provides an accurate measure of care economy productivity.

We strongly support the following:

- Significant long term investment in capacity and capability amongst academic health economists, the ABS, and the Department of Health, Disability and Ageing to work in partnership to develop productivity measures by strengthening data infrastructure, measurement frameworks, and research and analytical capability.
- Establish a new Medical Research Future Fund (MRFF) Mission on the Care Economy that provides an opportunity for health economists to undertake ongoing, long term research to develop a framework to measure care economy productivity and, importantly, provide ongoing evidence on the impact of policies designed to improve it. This should include a scheme for non-clinical research fellowships.
- Extend the evaluation, regulation and decision making processes to the disability and aged care sectors, to help government identify and invest in high value care, and help government identify and disinvest in low value care.
- Review and amend National Competition Policy to include a focus on the non-market care sector, since the effects of encouraging competition are mixed, and more evidence is needed to ensure optimal policy.

⁷https://www.york.ac.uk/media/che/documents/papers/researchpapers/NHS%20prod%20update%20202223_draft%20final_CORRECTED%20VERSION_20250513%20with%20cover%20and%20front%20matter.pdf

⁸ <https://www.abs.gov.au/statistics/research/experimental-hospital-multifactor-productivity-estimates>. The ABS has also published a productivity measure of the whole Health and Social Assistance industry, discussed below.

⁹ <https://www.pc.gov.au/inquiries-and-research/measuring-healthcare-productivity/>

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Below we directly address a selection of the questions raised in the Senate Discussion paper.

Challenges in measurement

- *What are the limitations of Australia's current productivity measurement frameworks?*

The ABS wants to improve measures of productivity in the care economy and we concur with their analysis of the problems and the specific challenges that must be overcome to measure productivity.^{10,11,12} It will require ongoing methodological development and detailed annual data collection as care economy productivity is expected to change substantially, where new models of care, new technologies, and new funding models are on the horizon.

The ability to measure service quality to estimate care economy productivity was highlighted by the ABS as a limitation of its experimental hospital multi-factor productivity estimates.¹³ Measuring service quality matters because improvements in survival rates and quality of life resulting from new models of care and technology can help accurately capture the changing value of care economy services over time. While the Productivity Commission's recent publication, showing an alternative approach to measuring healthcare productivity included changes in care quality using Quality-Adjusted Life Years (QALYs), this only covered about one-third of health care services.¹⁴ These, and past efforts, highlight the continuing need for investment in better data and investment in research to achieve robust and comprehensive measures.

A comprehensive, flexible framework for measuring productivity is required for the care economy, since providers deliver a wide variety of services valued differently by care recipients. There is not one national measure of output in the care economy that uses the same metric to represent value. Moreover, some services do not measure outcomes, while for other services it is challenging to attribute outcomes to services, given that socioeconomic characteristics and patient behaviours can substantially impact wellbeing outcomes. Fortunately, recent access to population-level linked government administrative datasets held by the ABS and the Australian Institute of Health and Welfare (AIHW) make it potentially feasible to attribute outcomes to inputs and to evaluate the impact of policies designed to improve productivity using real-world data.

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Another unique feature of measuring care economy productivity is the need to estimate a service price. Unlike other service industries, like Financial and Insurance Services, many care economy services are either not traded in a market (e.g., public hospitals) or are traded in a quasi-market where government heavily subsidises services (e.g., residential aged care). Prices for these services either don't exist or are not set by demand and supply, and so cannot be used as measures of value.

¹⁰ <https://www.abs.gov.au/statistics/research/disease-based-output-measures-hospitals#:~:text=Outlines%20the%20approach%20for%20constructing,level%20expenditure%20data%20from%20AIHW.>

¹¹ <https://www.abs.gov.au/statistics/research/experimental-hospital-multifactor-productivity-estimates#limitations>

¹² <https://www.abs.gov.au/articles/primer-labour-productivity>

¹³ <https://www.abs.gov.au/statistics/research/experimental-hospital-multifactor-productivity-estimates#limitations>

¹⁴ <https://www.pc.gov.au/inquiries-and-research/measuring-healthcare-productivity/>

● *How do measurement gaps in non-market sectors affect understanding of overall economic performance?*

Measuring productivity is vitally important to improving Australia's care sector. Given that the care economy is the largest employer in Australia, without productivity improvements in the care economy, Australia will struggle to substantially improve economic growth and long-term living standards. A more productive care economy delivers direct health benefits to care recipients and indirect productivity benefits to the entire labour force by reducing time otherwise spent off work for illness.

Given the care sector is so large, any biases because of the poor measurement of productivity will also bias overall national estimates. This has substantial implications for national policy and spending decisions that are informed by these data. In addition, because health outcomes are not routinely measured within the health care sector (there are better national measures of quality for aged care and disability services - see below for more information), it is challenging to design and monitor services that improve performance, productivity and value in health care.

- Current care economy productivity estimates are inadequate to help the government identify where it should spend its money to improve productivity, or to identify providers and healthcare systems that have high productivity. This reduces the capacity for organisations to benchmark themselves and improve productivity.
- Productivity estimates often equate the value of inputs with the value of output and fail to capture changes in service quality. If quality is increasing, this means productivity estimates are biased downward and any real productivity gains are not captured in the national accounts. This is one explanation for measures showing low care economy productivity growth¹⁵ despite significant reform and substantial diffusion of new technology.
- Downward biased productivity estimates could distort government investment and lead to investment in low value care if care economy productivity is slow to respond because of poor measurement.
- Australia is undertaking major reforms in aged care and disability care and seeks major reform in state and territory healthcare systems through the National Health Reform Agreement. Reforms are significantly impacting the care economy, but without a reliable way to measure productivity, the government cannot assess whether these reforms have improved efficiency rather than shift costs, and the value of additional government spending.

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● *How does Australia compare to international best practice in measuring productivity?*

In 2005, a landmark review by Sir Tony Atkinson set nine core principles of best practice public sector productivity measurement, intended to approximate the types of measure possible in market sectors. These principles include adjusting for quality change,

¹⁵ <https://www.abs.gov.au/statistics/research/experimental-hospital-multifactor-productivity-estimates#limitations>

comprehensive measures of inputs (i.e. not focussing solely on labour), and explicit acknowledgement of uncertainty and margins of error.¹⁶

Comprehensive, quality adjusted measures of health system productivity (not including aged care or disability services) have been developed in the UK, for the National Health Service (NHS). These are based on the measurement of changes in a generic preference-based measure of quality of life, The EQ-5D, for individual patients before and after NHS treatment. The measure is now updated annually by the University of York and the UK Office for National Statistics (ONS), which has applied it to all UK countries. This solid, evidence-based methodology now provides the basis for robust measurement and modelling, underpinning policy development such as whether the NHS will be able to achieve an ambitious 2% year on year productivity improvement and be fiscally sustainable.¹⁷

In general and internationally, there is growing recognition of insufficient measurement of the value of care economy services, including the impact on the economy and national wellbeing. Spending on health, aged care and disability services is often recognised only as a cost, not as a vital input to other services and to wellbeing. One approach to giving visibility to, and accounting for the impacts of these often invisible sectors, is to create a Satellite Account to the National Accounts.¹⁸ The Australian Treasury's Wellbeing Framework¹⁹ could be used as the foundation for this. The Wellbeing Framework has also led to an expanded and more frequent General Social Survey in 2026 to expand these measures, but these are not yet linked to specific industries or sectors and so cannot yet be used in the National Accounts.

The availability of data is central to implementing and improving productivity measures. Australia has strong foundations, built on the linkage of large population-level datasets by the ABS and AIHW, and investment in their continuing development. The key next step is significant investment in the development and integration of quality, health outcome, and wellbeing measures.

● *How can official productivity measures of the sector be improved, to facilitate policy making and resource allocation?*

First, there are a range of technical issues. Use of the aggregate 'Healthcare and Social Assistance' classification is too broad given its size and importance. We recommend disaggregation of this classification when calculating productivity, to allow for the diversity of services and measures of output, as well as quality.

Second, the key issue is not measuring costs but **measuring outputs in terms of the value and wellbeing created, rather than using simple measures of activity**. Measuring care

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¹⁶ Atkinson, A. 2005. Atkinson Review: Final Report, Measurement of Government Output and Productivity for the National Accounts. Palgrave MacMillan. (www.uksa.statisticsauthority.gov.uk) These principles have recently been updated by the UK National Statistician to recommend measuring outcomes rather than activity, to expand measures to include better measures of activity outside of hospitals and longer term gains in health and greater transparency about assumptions, methods and uncertainty. (Office for National Statistics. 2025. National Statistician's independent review of the Measurement of Public Services Productivity, www.uksa.statisticsauthority.gov.uk)

¹⁷ <https://www.health.org.uk/funding-and-partnerships/programmes/nhs-productivity-commission>

¹⁸ <https://www.aeaweb.org/articles?id=10.1257/aer.20201480>

¹⁹ <https://www.abs.gov.au/statistics/measuring-what-matters>

quality is an essential building block for both measuring productivity and understanding how to increase productivity. This would not only improve productivity measurement for governments but would allow service providers to make smarter decisions about how to improve their care.

We believe the best productivity measures and the resulting chance to improve productivity in the care economy should be driven by routine collection of new preference-based health outcome measures at the service level. This would enable aggregation of service-level measures to broader sectors, as well as comparison (or mapping) of measures across sectors.

Different measures of health outcomes and wellbeing are required for different uses, and many of these exist. To measuring productivity over time in the national accounts, a measure would require outputs to be weighted by a quality measure that is comparable across all sectors. For example, the NHS used the EQ-5D which was adapted for use in national productivity measurement by the University of York's Centre for Health Economics. EQ-5D is a standardised measure of quality of life and, combined with length of life, is used to measure Quality Adjusted Life Years. This allows outcomes to be compared across different health conditions and interventions in a standardised way. Health economists have been at the centre of adapting EQ-5D for use in Australia and internationally²⁰.

Clinicians typically do not use these measures because they are too general. They hold less value for clinicians looking to improve health outcomes compared to more patient-centred Patient Reported Outcome Measures (PROMs) for specific disease and conditions. These measures describe outcomes without valuing them and do not always combine them into a single index. For example, clinical measures often used in disease registries are very specific to the health condition and are mostly used for clinical evaluation. They cannot be used to measure productivity or to make decisions about how to allocate resources between treatments for different health conditions. Importantly, they do not incorporate patients' preferences, which are essential to measuring 'value'.

More recently, health economists have also been at the centre of developing measures in aged care and disability care. Health economists at Flinders University designed measures now being used in aged care²¹. The Quality of Care Experience-Aged Care Consumers (QCE-ACC) and Quality of Life-Aged Care Consumers (QOL-ACC) measures are the first preference based aged care experience and quality of life measures co-designed with older people globally. In response to recommendation 22 of the Royal Commission's final report, the QOL-ACC and QCE-ACC were licensed to the Australian Government and translated nationally from April 2023 as integral components of the National Aged Care Mandatory Quality Indicator Program (QI Program).

The Disability Wellbeing Index (DWI) was launched in 2025 and was developed by health economists at Monash University. Funded by the National Disability Insurance Agency, the DWI was developed as a person-centred outcome measure of wellbeing for people with disability, aiming to reflect their views on what is important in life. It was designed to be a valid and sensitive outcome measure that could be used to monitor outcomes, evaluate the comparative performance of programs and providers, provide information to allow better choices, and promote the use of those services and supports that provide the best value for

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²⁰ <https://www.sciencedirect.com/science/article/pii/S1098301511014926>

²¹ <https://link.springer.com/article/10.1007/s11136-025-04081-z>

money. This has not yet been implemented widely yet by the NDIA, but we strongly recommend that it is.

The aged care measures (QOL-ACC and QCE-ACC) show that it is possible to use these measures nationally at scale. Some States already conduct large sample surveys of patients but these typically do not include preference-based health outcome measures. For example, the New South Wales Ministry of Health collects Patient Reported Outcome Measures (PROMs), demonstrating system-wide collection is possible, but these PROMs are not preference-based and must be mapped to a preference-based measure before being used in an economic evaluation.²² In the UK NHS the EQ-5D was administered to patients before and after their hospital admission so that improvements in quality of life could be measured.

The productivity benefits from national preference-based health outcome measures would be substantial. They could be used to directly quantify healthcare system productivity, filling a major productivity measurement gap that would correctly inform government spending and policy. They could also be used to better understand the impact of their care on consumers, providing further opportunity to improve care models and improve productivity. It would be possible to better identify and disinvest in low or no value care. This is critical considering 30 per cent of care is low or no value and 10 per cent results in harm.²³ Consumers could use these measures, combined with quality and cost information, to make more informed provider and treatment choices.

There needs to be significant investment in health economics research to produce better measures of productivity in the health care, aged care and disability sectors, and more investment in health economics research on how to improve productivity across these sectors. Health economists are ideally placed to conduct this research as they have been conducting research in this area for many years.

Industry contributions to productivity, including the non-market sector

- *How significant is the contribution of the non-market sectors in Australia's overall economic performance?*

The sheer size of the care economy means that its contribution is significant. The ability of individuals to participate in the workforce and in society is directly related to their health and wellbeing. There is always a risk that a focus on 'economic performance' ignores wellbeing and treats economic performance as a final outcome or an end in itself. Supplementary measures are now often used, alongside GDP, to show changes over time in wellbeing as well as the impact of factors not included in GDP, such as informal and unpaid care. The Treasury's [wellbeing framework](#) provides an Australian foundation for this, and we strongly support its development and integration into the national accounts.

- *Why has productivity performance been lacklustre in Australia's non-market sector?*

²² <https://link.springer.com/article/10.1007/s40273-022-01157-3>

²³ <https://link.springer.com/article/10.1186/s12916-020-01563-4>

We question whether productivity in the care economy has been ‘lacklustre’ because we don’t have reliable metrics to make this statement. For example, official measures of hospital productivity show it was flat before COVID-19²⁴, but the Productivity Commission’s estimates for a third of health services show productivity grew by 3% across a similar period. This provides potentially conflicting evidence for policy, and so policy conclusions are difficult to make with better and more comprehensive measures. Only once we have reliable longitudinal measures of productivity across the whole sector (or a representative sample of it) can we identify and prioritise opportunities to for productivity growth.

Australia's regulatory burdens that limit productivity

- *Which regulatory requirements impose the greatest burden on productivity growth and how could these be streamlined without compromising public interest or safety?*

Regulation is good and necessary to ensure value is created in the non-market sector since value is not routinely measured, whereas in market sectors regulation is often regarded as a potential brake on market innovation. In non-market sectors, regulatory requirements protect public safety and quality and ensure the best use of taxpayers money and other resources. Where there is market failure, markets need to be regulated to ensure the best outcomes for consumers. Regulation of care economy providers is necessary to support improved productivity, especially where outcomes are not measured and demand side policies such as improving choice and information may have limited impact due to lack of information. This does of course impose regulatory compliance costs on providers, but these could be reduced with more standardised systems and the careful use of AI.

We would argue that some areas of regulation should be strengthened across the health, aged care and disability sectors. The processes used to decide on public funding of pharmaceuticals (through the Pharmaceutical Benefits Advisory Committee, PBAC) and medical devices and services (Medical Services Advisory Committee, MSAC) are used to ensure that only technologies and pharmaceuticals which are cost-effective, that is contribute most to productivity, are funded by taxpayers. There has been a recent review of Australia’s Health Technology Assessment processes and the government’s response should be aimed at strengthening these processes.²⁵ The role of health economics and economic evaluation of new technologies is essential in ensuring high productivity and value for taxpayers. There is much pressure from industry to weaken these processes, letting in lower value technologies and pharmaceuticals. The UK recently weakened their health technology assessment processes for pharmaceuticals in response to international pressure, with health economists predicting 4,500 additional deaths and a loss of almost 120,000 years of life in good health each year.²⁶ Using these economic frameworks can save lives and improve quality of life at scale, whilst using freed up resources for more valuable uses.

Similar decision-making process are being established by the National Disability Insurance Agency to ensure value for money. These should be strongly supported. However, no such processes are used by the private health sector or by public hospitals. New technology and innovation is not always better than what already exists.

²⁴ <https://www.abs.gov.au/statistics/research/experimental-hospital-multifactor-productivity-estimates#limitations>

²⁵ <https://www.health.gov.au/our-work/hta-review?language=en>

²⁶ <https://www.york.ac.uk/media/che/documents/Open%20letter%20to%20government%20on%20the%20impact%20of%20higher%20medicines%20costs%20for%20the%20NHS%2013112025.pdf>

Effectiveness of Australia's competition policy

- What is the relationship between strong competition and productivity growth?
- How does competition influence innovation, product quality, and consumer choice?
- Is Australia's National Competition Policy effective, or does it need to be updated?

Competition policy in the care economy is a difficult policy area because of the extent of market failure and informational asymmetries. Our research and reviews have shown that the effect of competition is mixed. Encouraging competition **will not** lead to improved outcomes **and quality**, and lower costs, especially when outcomes are not routinely measured and consumers have little understanding, information or choice. The effects depend heavily on the details of each market²⁷. Demand-side initiatives, such as price and quality transparency, may have limited effects and benefit only those who have the capability and education to use such information, and so can widen inequalities in access. For example, the publication of specialists' fees can have mixed effects and, perversely, may increase fees²⁸, and may increase inequalities if only more educated people are able to effectively use and interpret the information.²⁹ Careful evaluation and further research is required.

We recommend National Competition Policy be amended and reviewed with specific reference to empirical evidence on the non-market sector and the production of a research agenda to support this.

Dynamism of Australia's labour market

How do labour market policy and regulatory settings influence labour market dynamism and productivity growth?

- What are the main structural and other barriers to labour market productivity growth (for example, in relation to occupational licencing, skills recognition and portability, and other regulations)?
- Impact of labour (including skilled labour) shortages on productivity performance?
- How can these barriers best be addressed by policymakers and others?

Changing the care economy's labour market settings to improve productivity requires careful consideration, to protect consumers' access to services and equip the workforce to provide the best possible services. Often, improving the dynamism and productivity of the workforce rests on investment outside the workforce, in infrastructure including data and digital supports, allowing experts to provide the best possible services.

Changes in expectations, training and knowledge are changing how care can be provided. In primary care, for example, nurses' "scope of practice" has changed so they can undertake many tasks formerly in the purview of GPs, with similar outcomes and freeing GP time. Sometimes regulation is slow to adapt; constraining the productivity potential of the system and put unnecessary pressure on the workforce. A recent independent review of scopes of practice sets out a way of "unleashing the potential" of the health workforce.³⁰ The

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²⁷ <https://www.ncbi.nlm.nih.gov/books/NBK589275/>

²⁸ <https://www.ncbi.nlm.nih.gov/pubmed/32576391>

²⁹ <https://www.sciencedirect.com/science/article/pii/S0167718721000096>

³⁰ <https://www.health.gov.au/our-work/scope-of-practice-review?language=en>

government has not yet responded; we encourage the adoption of recommendations which would have a significant impact on productivity in the primary health care sector.

The regulation of labour markets in the health care sector regulatory system is particularly complex, since it crosses sectors (e.g. education and the care sector), and includes both economy-wide regulations as well as bespoke, some of which are set by health practitioners' own professional bodies. This complexity and divided responsibilities can impede change, and sometimes means regulations have unintended impacts or lag behind key social changes. For example, it can be challenging to ensure that training programmes are able to keep up with innovations and changes in demand, leading to shortages and constrained productivity. We recommend simplifying or merging these regulatory structures, and at a national level,

Migration and care economy productivity. The provision of healthcare services in rural areas, and the labour market for lower skilled jobs in aged care and disability care, are heavily dependent on migration from other countries. For example, over 50% of medical practitioners in non-metropolitan areas graduated overseas. The care sector relies heavily on migration and this should be supported. It is costly and inefficient to move to self-sufficiency. Twenty five years ago a policy of self-sufficiency for doctors in Australia was declared, and though the number of doctors, particularly specialists, have increased significantly, the proportion in rural areas and areas of need increased only slightly³¹. Increasing supply is one thing, but ensuring they are distributed according to need, where productivity can be maximised, is another and requires further evidence about “what works” and, perhaps, careful regulatory design.

³¹ <https://connectsci.au/ah/article-abstract/49/5/AH25107/238009/Evolution-of-the-health-workforce-lessons-from-the>